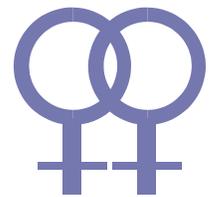


BEING OUT, STAYING SAFE



An STD Prevention Curriculum for
Lesbian, Gay, Bisexual and Queer Teens

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Acknowledgments

We want to express our deep gratitude to the following individuals/organizations for their invaluable help and support during the development of this curriculum:

Don Dyson, PhD and The New Jersey Department of Health and Senior Services, for recognizing the importance of creating this curriculum and for funding its development.

Molly McClure and TR Richardson – for taking the time to review, tinker with, and help us reflect on the content of the curriculum to ensure sensitivity and inclusion – and Maureen Kelly, for inspiring the curriculum’s title.

Bob Ivancic, Marlene Pray, Kiki Towhill, and Lori Stern for helping us to collect feedback from LGBQ youth about what they wanted to have included in an STD curriculum written specifically for them.

Anke A. Ehrhardt, PhD, Joyce Hunter, DSW and others at The HIV Center for Clinical and Behavioral Studies at The New York State Psychiatric Institute and Columbia University, for assistance in finding research pertaining to lesbian, gay, bisexual, and queer youth.

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Note: The order in which the authors' names appear was selected by a random process. This was a joint effort of equal contribution by both authors.

The authors would like to acknowledge the many sexuality, health, and other educators who are currently in the field and who have come before us. While this curriculum is an original work, the formats of certain activities – such as brainstorming and self-reflection – have been done and will continue to be done for years. We appreciate having the opportunity to take these formats and tailor them specifically to this important topic.

INTRODUCTION

This curriculum is about preventing Sexually Transmitted Diseases (STDs) for lesbian, gay, bisexual, and queer (LGBQ) teens. It is based on the belief that honest, medically accurate information presented in a way that is both interactive and skills based, is theoretically grounded, and is both inclusive and respectful of LGBQ youth, will best help them to protect themselves from negative outcomes related to high-risk sexual behaviors.

Why This Curriculum?

A major focus of sexuality education programming is STD and HIV prevention. Numerous curricula on this topic are currently available and used in public schools and community agencies across the country. What virtually all of these curricula have in common, however, is their exclusive, or almost entirely exclusive, focus on heterosexual adolescents. Those schools and agencies that include lesbian, gay, bisexual, and queer youth do so mostly by adapting the materials that were written for heterosexual youth so that the language and examples are more inclusive.

LGBQ youth get very little, if any, positive reinforcement or opportunities to see themselves in a positive light at school. The vast majority of education in the United States is heterocentric – meaning, it is provided within the context of heterosexual individuals, needs, and experiences. Sexuality education is no different – lessons on relationships usually discuss heterosexual couples exclusively; references to “sex” imply penis-vagina intercourse between male and female partners only; pregnancy prevention efforts ignore the fact that people who identify as lesbian, gay or queer may still be in sexual relationships that place them at risk for pregnancy. Sexual orientation or homosexuality is among the three most likely topics to be excluded from a sexuality education course, along with abortion and how to use condoms (Hoff and Greene, 2000). In other areas, if homosexuality is addressed, it is done so only in passing, within the context of a negative health concern, such as HIV risk (Friend, 1993). In textbooks used to teach about human sexuality, there are few references to any sexual orientation other than heterosexuality – and the references that are there tend to be negative (Bailey and Phariss, 1996).

The most common topic addressed in school-based sexuality education is HIV/AIDS and other sexually transmitted diseases (STDs), yet only 41% of teachers address anything pertaining to non-heterosexual individuals. (Hoff, Greene, et. al. 2000). When it comes to HIV/STD prevention, however, there is ample research that has shown that the issues that LGBQ youth face when dealing with HIV/STD risks are very different from those of their straight peers. These include fear of coming out, isolation, and lack of access to resources welcoming to them specifically (Hunter and Schaecher, 1994). Lesbian, gay and bisexual teens are generally at higher risk for contracting HIV/STDs than heterosexual teens. They report more high-risk sexual behaviors, more lifetime and recent sexual partners, more alcohol and drug use before last sex and more pregnancies. In one study, however, LGB students who received gay-sensitive instruction (gay friendly curricula, materials and teachers) reported fewer of these risk factors than a comparison group of LGB teens who did not have such educational support (Blake, et. al., 2001). Because the curricula that currently exist do not address the specific needs of this

population young people who identify as anything other than heterosexual have no other choice but to take heterocentric information and try to adapt it to their own lives and relationships. This is problematic for two reasons: first, it can be extremely difficult to adapt the information, which often does not apply to their lives. Second, forcing non-heterosexual youth to adapt the information places an unfair burden on a group of young people who are at just as much risk for STDs as their heterosexual counterparts – and in many cases, at higher risk.

Currently, lesbian, gay, bisexual and queer teens are being left at tremendous risk for STD and/or HIV contraction and transmission. (HIV Center for Clinical and Behavioral Studies, 1992; Hunter and Alexander, 1995). This curriculum was designed, therefore, to provide accurate, direct information about STD prevention and safer sex tailored specifically to the needs of LGBQ youth.

Being Out, Staying Safe focuses on the specific issues that LGBQ youth face in negotiating safer sex and avoiding STDs and HIV. It is grounded in Social Learning Theory, and as such, addresses issues of susceptibility, personalization, efficacy, self-efficacy, social norms, and skill building as they apply specifically to LGBQ youth. Unlike other programs that use fear and negative messages and attempt to keep youth from having sexual relationships, a popular approach that to this point has shown no evidence of effectiveness in reducing STD transmission (Kempner, 2001), this curriculum provides a positive approach to sexuality as well as support and affirmation for LGBQ youth in their efforts to maintain sexual health, specifically around HIV and STD prevention.

Being Out, Staying Safe has a narrow focus on one aspect of sexuality education: the prevention of STDs and HIV. Current statistics relating to STD rates among teenagers and young adults provide ample support for the need of this type of education. Nonetheless, we want to be clear that sexuality education is about much more than preventing disease. Sexuality education should focus on raising a person’s self-esteem, providing unbiased factual information, encouraging respect for oneself and others, and offering opportunities for practicing the skills that will enable a person to make decisions about which she or he will feel good throughout her or his entire life. This curriculum is designed to do that, focusing on one sexuality-related topic: avoiding behaviors that will put a person at risk for sexually transmitted diseases.

Throughout this curriculum, the phrases “having sex” and “sexual activity” are used to refer to a range of sexual behaviors, with particular emphasis on those behaviors that may put people at risk for STD transmission or that may serve to reduce that risk. It is important to be clear with participants up front, that despite the widespread public use of the phrase “having sex” as meaning penis-to-vagina sexual intercourse, this curriculum takes a much broader view.

The Audience

In writing this curriculum, we specified our audience as “lesbian, gay, bisexual, and/or queer” or “LGBQ” youth. In doing so, we may raise questions about why we chose this group and not youth of other sexual orientations and gender identities. Our decisions around this were reflective and intentional. They also merit explaining so that educators will both understand and be prepared to explain the curriculum’s rationale.

The “alphabet soup” of sexual orientation and gender identity with which educators may be familiar is “LGBTQQIA”. These letters stand for, in order: lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual. In developing the curriculum, we chose to focus on *sexual orientation* – the gender(s) of the people to whom one is attracted sexually. For the purposes of an STD prevention curriculum, a person’s behaviors are what put that person at risk for a particular infection. This is why we eliminated “asexual” from the curriculum – to be at risk for an STD, one must be doing something sexual in the first place. This is also why we do not address intersex issues, because one’s biological or chromosomal composition does not affect one’s risk for STDs – one’s behaviors do. We also make the assumption that many of the young people who are likely to be a part of groups in which this curriculum would be used have had some same-gender attractions and/or behaviors – which is why we do not talk about questioning youth.

Transgender individuals are people whose gender identity does not fit neatly into the majority culture’s binary categories of “male” and “female.” Just as someone might identify as male and gay or heterosexual or bisexual, a transgender person may identify as transgender and lesbian, or gay, or heterosexual. In recent years, transgender individuals and lesbian, gay, and bisexual people have been grouped together because, as sexual minorities, they share many issues and perspectives. At the same time, however, transgender issues are unique from LGB issues in many ways. Again, however, it is not one’s gender identity that puts one at risk for STDs – sexual behaviors are what put a person at risk for STDs. As a result, we felt it would be disrespectful to refer to transgender youth without specifically addressing them in the curriculum. Based on their sexual orientation, however, we do feel that the STD risks of transgender youth are incorporated implicitly into the curriculum.

“Queer” is an historically negative term that many LGBTQQIA individuals of all ages have begun to use more frequently to identify themselves. As we mention later in this introduction, however, many do not. Incorporating “queer,” however, helps to raise an umbrella over our intentions and include any young person for whom any of the other labels (LGBTQQIA) do not resonate, as well as lesbian, gay, and/or bisexual youth who simply choose to identify as “queer”.

Regardless of these variations, if a person identifies as anything other than heterosexual or has a sexual relationship that is anything other than between people of different genders, it is highly unlikely that they have received information that is specifically geared to or affirming of who they are. This curriculum speaks to these young people by using examples, language, and materials that reflect the realities in which they live, love, and are sexual beings.

The Theoretical Basis for This Curriculum

This program has been built upon six important theory-based concepts, which address all three domains of learning: cognitive, affective and behavioral. Well-documented research in the field of sexuality education has established that programs that are well grounded in educational theory and are narrowly focused on specific measurable objectives, are the most successful in producing desired cognitive, affective, and most importantly, behavioral outcomes (Kirby, 1997). Focused, theory-based programs become even more essential when there are constraints

on time. Lack of instructional time is one of the greatest obstacles to effective sexuality education. Few schools, agencies or organizations have the ability to spend the amount of time they would like teaching comprehensive sexuality education. Therefore, it becomes extremely important that the time be spent well by using proven, theory-based models to target specific outcomes.

While there are a number of different social learning theories that have been applied to sexuality education, they have certain concepts in common:

Personalization. The learners need to believe that the information being provided is relevant to them personally.

Susceptibility. The learners must believe themselves to be vulnerable to whatever the negative consequence may be (failure to finish school, infection, etc.).

Efficacy. Learners have to believe in the effectiveness of the behaviors they are being taught in achieving the desired outcome.

Self-Efficacy. Learners have to believe in their own abilities to carry out the decisions/behaviors that are being asked of them.

Social Norms. Learners must perceive that there is social support for the beliefs and behaviors they are being asked to embrace.

Skills. Learners must, in actuality, have the skills necessary to carry out the behaviors and ideas that are part of the program (Hedgepeth and Helmich, 1996, pp. 70 - 72).

These six concepts are critically important to the development of effective education in any topic area, especially those in which behavioral outcomes are anticipated. They are particularly key in a curriculum where the desired outcome is a decision to avoid behaviors that would put one at risk for a sexually transmitted disease or to adapt behaviors that would decrease that risk, especially if one is already engaging in risky sexual behaviors.

Using these theoretical constructs, this six-session curriculum has been developed to complement existing, more comprehensive sexuality education programming for LGBQ youth. Included are:

- Accurate, comprehensive information about risks related to sexually transmitted diseases and HIV that is geared specifically to LGBQ teens.
- Opportunities for reflecting on the personal relevance of the information and on individual susceptibility to these infections.
- Demonstrations of and practice in using safer sex methods.
- Overview of and practice in effective communication skills in discussing safer sex.
- Other interactive skills-building activities.

How to Use This Curriculum

The six sessions in *Being Out, Staying Safe* are designed to be completed in two hours each. While they are written sequentially, each session building upon the one before it, every session can also be used as a complete stand-alone workshop, depending on the needs of participants and the time available for the program. Individual sessions can also operate as booster interventions for groups that have covered STD prevention materials previously.

An optional feature that can be added to this curriculum is a “Parking Lot.” The concept of the parking lot is a way to provide time and space for participants to ask questions or raise issues that may not be directly related to the topic at hand in any given session but are nonetheless important. Invariably, when the topic of STD prevention is discussed, it will raise other questions for participants. Questions about sexual functioning, sexual orientation, other behaviors and experiences and relationships, are all related to STD prevention. Because these sessions are so full and timed to the minute, however, such tangential but important conversations may not always be possible. Therefore, at the beginning of the first session, the instructor can introduce the parking lot, a piece of newsprint on which questions and topics for discussion will be recorded as they come up so as to allow the primary lesson to continue while saving the additional topics for another time.

The parking lot can be used in a few ways. If there is a question recorded during a session that can be answered relatively quickly, the instructor may decide to address it at the beginning of the next session during re-entry. If a question comes up in one session that relates directly to a topic that the instructor knows will be covered in a later session, s/he may suggest putting it in the parking lot and then bringing the issue back up during the session in which it is covered. For more in-depth or complex issues or questions that will require additional time, the facilitator may choose to plan additional sessions at the end of the curriculum. Alternatively, if there is flexibility with time, the instructor may choose to build in an additional 30 minutes to each session in order to include a fifteen minute break and fifteen minutes to address parking lot issues.

Important note: *If there is no time available to build in to address additional issues, the instructor should not introduce the parking lot, as this can cause frustration and resentment among participants. Or, if s/he does introduce it, knowing that there may be insufficient time, s/he should explain to participants that it is likely that issues put up on the parking lot may not be addressed.*

The curriculum was designed to be used in mixed sex and gender groups, and includes examples of different kinds of relationships and behaviors. If, however, a group is composed of just one sex or gender, the curriculum can be adapted. In some cases, the instructor can alter language to reflect only the sex or gender in the room, and select examples or scenarios that match the sex or gender of participants in the group. A strong case can be made, however, for including the broader, more inclusive language and diverse examples regardless of the group composition. First, sexual orientation does not necessarily dictate sexual behaviors. People who identify as lesbian or gay may still engage in sexual relationships with people of a different sex or gender. Therefore, it is important for a group of lesbian teens, or a group of gay male teens, to

learn about pregnancy prevention as well as safer sex. Most of the information and skills in the curriculum are applicable to all teens, but may be applied differently.

Another consideration when teaching from this curriculum is the gender balance of the group. As with any program, specifically one related to sexuality, it is important that every voice and perspective is heard and represented, including, if not especially, minority perspectives and voices. This is a challenge for the facilitator no matter what the balance happens to be. When there is a great imbalance, however, this challenge becomes even greater. It is important for the facilitator in these situations to be proactive in making sure that opinions and experiences of groups that are underrepresented in the classroom are heard and considered. As LGBTQ teens often find themselves and their ideas marginalized or unrepresented in mainstream educational settings, it is even more important that that dynamic is not present in this program.

Curriculum Format Overview

Each two-hour session of the curriculum is independent, yet builds on the session that came before. Every module contains:

- The rationale for the session
- Goals and learning objectives
- The timing breakdown for the individual parts of the session
- Detailed, step-by-step instructions for the session, including:
 - ✓ scripted dialogue, when needed (this language is highlighted in quotes and italics)
 - ✓ possible responses from participants during various activities
 - ✓ materials and advance preparation needed
- “Notes to the Facilitator” – specific feedback or suggestions for educators to take into consideration as they teach a particular part of the session.

Language Used in the Curriculum

Throughout the curriculum, we use the terms lesbian, gay, bisexual and queer as examples of different identities that may be present in a group in which this curriculum is offered – keeping in mind, of course, that there may be people present who engage in sexual behaviors with people of the same or another gender without attaching a label to themselves. Although we use these terms in different ways on different occasions, we suggest the following brief guidelines when it comes to using language:

- ◆ **Everyone is an individual.** If it is important to determine how someone identifies – to ensure, for example, balanced representation in a small group activity – ask everyone how they self-identify. Do not assume that all the boys in your group or class identify

as gay, the girls as lesbian, and so on, unless this information has already been shared with you.

- ◆ **Many non-heterosexual people identify as queer...** This identity has been taken by many people who do not feel they fit into the mainstream culture's view of "acceptable" sexual orientation and gender identity: namely, a biological male or female who identifies as heterosexual and who only engages in heterosexual relationships. Many young people in particular are reclaiming the negativity historically associated with the term queer and find it empowering. For example, a lesbian, gay, or bisexual person might also identify as queer, or use "queer" interchangeably with LG or B.
- ◆ **...And many do NOT.** At the same time, however, educators should avoid making assumptions that just because they are working with teenagers everyone in the room embraces the term "queer". The focus should be on the group – regardless of whether people identify as lesbian, gay, bisexual, queer, homosexual, something else, or nothing at all.

Group Facilitation Techniques

Both small group and large group discussions are central to the activities in this curriculum. Group dynamics have a very strong impact on the functioning of a group and its ability to have effective, useful, learning experiences. More experienced health and sexuality educators are likely to be quite familiar with group process issues from their own extensive experience facilitating group learning. Newer educators, or those new to sexuality education, however, may find some guidelines helpful. Sexuality educators Evonne Hedgepeth and Joan Helmich (1996, pp. 39 - 60) make the following suggestions for facilitating interaction among people in groups:

- **Arrange seating so that learners can see and interact with one another.** Chairs aimed at the front of the room will aim the interaction in that direction. We recommend that this program should be done in a u-shaped or circle formation.
- **Pose open-ended questions or topics.** A key element to this program is exploring participants' thoughts and beliefs. In order to do this, avoid as much as possible questions for which only you have the answer.
- **Use newsprint or board to record main points.** The resulting list(s) become the group "memory" and shows progress. In addition, it is very empowering for young people to see something they have contributed recorded at the front of the room for all to see.
- **Move away from center stage when you don't have to be there.** From time to time, sit in the group or move to the back.
- **When a student is speaking, encourage her or him to speak to the group,** not to you. Having the group in a circle or u-shape will help facilitate this process.
- **Don't reply to all student input; wait for group members to reply.** If necessary, ask, "Any reaction to what so-and-so just said?" When appropriate, redirect questions asked directly of you, asking, "What do the rest of you think?"
- **Act as gatekeeper, watching the body language of quiet participants.** When someone seems to want to speak, invite her or him to do so.

- **Refer to ground rules when necessary**, especially with regard to respecting others' values and beliefs.
- **Use humor cautiously.** It is wonderful to be able to laugh during these sessions, especially if you are working with a close-knit group. At the same time, however, humor can be perceived by some as condescension, sarcasm, or even cross-examination. Be sure to intervene if any participant is being put on the spot.
- **Give students permission to feel uncomfortable**, and to express that discomfort – as long as it does not disparage anyone in the group.

Important Things to Keep In Mind

- **Gender balance.** This curriculum does not separate participants by gender. As a result, the facilitator needs to be vigilant to ensure that a group that may be dominated by one gender gives equal voice to everyone in the room. Among LGBTQ youth surveyed in preparation for writing this curriculum, a fair number of female-identified respondents wrote that they wanted “information that includes girls.” This request can apply just as easily to male participants seeking information that is male-specific in a group that is dominated by females. Be vigilant about ensuring that the discussion includes any one who may be underrepresented in the group, especially transgender youth.

- **The diversity within diversity.** Sexual orientation and identity can create a sense of community – but not every gay male experiences life in the same way. An African American gay male may have different experiences from a white gay male; a bisexual Latina teen may have different feelings about her identity than a bisexual Asian teen, and so on. In addition, not all gay people of the same racial or ethnic background will have the same experiences. When discussions merit it, elicit other types of differences and unique experiences to broaden the experience for everyone in the group.

- **Self disclosure.** People have different boundaries pertaining to what they are and are not comfortable sharing about their personal lives. Professionals who use this curriculum may need to consider aspects of personal disclosure they may not have considered before. For example, they may be perceived to be lesbian, gay, bisexual, and/or queer themselves. Those who are may or may not be out to their group; those who are not need to consider whether they feel the need to come out as heterosexual to the group. Each professional must decide how sharing or choosing not to share this information might affect the group. Any personal disclosure affects the dynamics of the group – and we cannot predict how until after we have shared something.

Self disclosure, whether as part of casual conversation or as part of the intervention or treatment process, should be well thought-out, and done with great care. Hedgepeth and Helmich (1996, p.99) offer the following questions an educator can ask her or himself as guidelines for determining whether and when self-disclosure is appropriate:

- Is this disclosure really necessary in order for me to make my point effectively?

- Is what I am thinking about disclosing developmentally appropriate for the age and experience level of the individual or group in front of me?
- Will disclosing this information have a potentially positive or deleterious effect on my relationship with this individual or group? How might it affect issues of trust between the group, individual group members, and myself? How might it affect the group's level of comfort?
- Is my timing for disclosing this information appropriate, keeping in mind that if it is shared too early in the relationship it could limit further discussion or turn the focus on me rather than the group?

Qualifications of Facilitators

No matter how well-conceived and written any curriculum is, it is only as good as the facilitator(s) who teach it. It is widely recognized that the single most important factor in any successful sexuality related program is the quality of the teacher. So, although the curriculum is written in a very user-friendly format, we ***do not*** suggest that it is necessarily easy to teach. The facilitator(s) of this program should have the following characteristics:

- ✓ A solid knowledge of sexuality content and effective sexuality education teaching methodology.
- ✓ Comfort with the topic of sexuality and a healthy understanding of her/his sexuality.
- ✓ Experience and comfort with, as well as respect for, LGBTQ teens and young people in general.
- ✓ A strong belief in the importance of sexual health and safety.
- ✓ An understanding and appreciation of, and desire to celebrate, diversity in race, culture, age, ability, gender identification, and sexual orientation.
- ✓ The ability to create a supportive, safe atmosphere.
- ✓ Recognition of the impact that her/his own values may have on her/his teaching about STD prevention and sexuality.
- ✓ Enthusiasm for teaching about sexuality and STD prevention.

Ideally, facilitators will receive training on this curriculum before attempting its implementation.

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SESSION ONE

”WHAT DO STDs HAVE TO DO WITH ME?”

RATIONALE:

Lesbian, gay, bisexual and queer (LGBQ) youth are bombarded with messages about being sexually active, about safer sex, and about sexual abstinence without necessarily having a clear understanding of these messages or being able to connect them to their own lives and experiences. Efforts to help youth avoid the risks of STDs, including HIV, are likely to be incomplete -- especially when it comes to LGBQ youth whose language, behaviors and experiences are largely ignored by most existing STD and pregnancy prevention programs. It is important, therefore, for participants to be able to identify specific issues that affect them personally as LGBQ teens in order to personalize the information and feel motivated to take action. Various learning theories posit that in order to do this, it is important for people to feel that they are susceptible to the risks that are the focus of any STD prevention effort. To further personalize this issue for participants, they will be asked to share some of their personal beliefs and values on the topic of STDs/HIV. Before any learning can take place, however, it is important to begin to develop group cohesion and a conducive learning environment through initial group-building exercises and the establishment of ground rules or group norms.

TIME:

2 hours

GOALS:

To help participants to:

- Begin to develop trust and cohesion within the group.
- Recognize their susceptibility to the risks of contracting STDs/HIV.
- Begin to personalize the issue of STD/HIV prevention.

OBJECTIVES:

By the end of this session, participants will be able to:

- Show their recognition of their susceptibility to STDs/HIV by discussing their susceptibility to these infections after participating in a risk-estimate activity.
- Demonstrate their ability to assess their own belief and value systems by participating in a values clarification activity about STDs/HIV.

MATERIALS:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Blank newsprint pad and easel | <input type="checkbox"/> “Program Goals and Values”
Facilitator Resource |
| <input type="checkbox"/> Newsprint markers | <input type="checkbox"/> Small (3” x 5”) index cards, enough
for each participant to have one |
| <input type="checkbox"/> Tape | <input type="checkbox"/> Pens or pencils, enough for each
participant to have one (as needed) |
| <input type="checkbox"/> “Find Someone Who” handout,
enough copies for each participant,
<u>OR</u> “Stand Up If” Facilitator
Resource | |

ADVANCE PREPARATION:

1. Write the Program Goals and Values listed in the facilitator resource/handouts section on newsprint, to be posted and discussed during the introduction.
2. Mark each index card with a small, capital letter in pencil on the back lower right hand corner as follows: approximately 10% of the cards should be marked with a capital “S.” Each of the remaining cards should be marked with one of the following letters distributed evenly among the cards “L,” “A,” “D,” “U.”
3. Make four signs: “STRONGLY AGREE,” “SOMEWHAT AGREE,” “SOMEWHAT DISAGREE,” “STRONGLY DISAGREE.” Post them along one of the walls in the room to create a continuum from “strongly agree” to “strongly disagree”.

PROCEDURE:

Overview and Introductions (10 minutes)

1. Introduce the curriculum by welcoming participants enthusiastically and introducing yourself. After going through an environmental overview, such as how long and for how many sessions you will be meeting, the location of rest rooms, and any other logistical information, say:

“Today we’re going to begin talking about Sexually Transmitted Diseases, or STDs, including how to reduce your risks for them. This includes HIV, the virus that causes AIDS. How many of you have had some kind of education about this topic before?” Acknowledge the hands in the group, then say, “There are many approaches to this topic. Some encourage young people to refrain from any kind of sexual activity. Some make them aware of the dangers and how to avoid them. What is unique about this program, however, is that it has been designed specifically for young people who identify as lesbian, gay, bisexual, or queer. It is based on research about STD/HIV prevention. The content also came from surveys of LGBTQ youth from around the country, who were asked what they felt they needed to know about this topic.

We will be talking about issues that specifically affect LGBTQ teens in your efforts to stay safe and healthy. We will also be using the word ‘sex’ fairly often. For the purposes of this program, when we say ‘sex,’ we are referring to a wide range of sexual behaviors, not one particular behavior.

At the end of the program, we hope you will feel more able and ready to protect yourselves from contracting or transmitting STDs, including HIV. So, let’s get started!”

2. Go around the large group and ask each participant to say their first name, one hope they have for this program, and one concern they have. Record these on two separate sheets of newsprint.

3. After everyone has gone around, acknowledge the wide range of hopes and concerns as well as similarities among the responses. Let the group know that you will make every effort to address both the hopes and concerns of the group as you go through.

Note to the facilitator: *You can also use this as an opportunity to let people know which expectations are not likely to be met during these sessions. For example, if someone says, “I hope we get to see videos of people having safer sex” you can say, “Well, that’s not part of this curriculum, but we’ll be doing a lot of other important stuff instead.” If the group is already well-established and knows one another, they do not need, of course, to introduce themselves to each other. It is still a good idea, however, to explore their hopes and concerns for the session.*

3. Save the newsprint, and keep it for the last session.

Group Building (25 minutes)

Note to the facilitator: *The type of group-building activity you do will depend on the number of participants in your group. If the group consists of at least 12 participants, consider doing Option A, “Find Someone Who...” If there are fewer participants, you can lead the group in Option B, which is an activity called “Stand Up If...”*

Option A: “Find Someone Who...” (10 minutes)

1. Pass around handout with the title “Find Someone Who...” Provide the group with the following instructions:

- *“Move around the room and find a person for whom each of the examples applies.”*
- *“If the example is a talent or knowledge-based question – such as, ‘Can stand on one foot for 5 seconds,’ make sure the person shows that they can actually perform the task.”*
- *“Once the person has finished, have her or him sign or initial your piece of paper on the line next to the description of what s/he did or said. Then move on to someone else and continue as you go on.”*
- *“Try to get the initials of as many people as possible. Each person, however, can only sign a sheet once; one person cannot stand and initial as many examples as apply to her or him on one person’s sheet.”*

2. After about 5 minutes, have everyone sit down, and determine who obtained the most signatures by a show of hands.

3. Process the activity by asking the following questions:

- *“What was it like to do this activity? What was [insert participant responses] about it?”*
- *“Which questions were most difficult to get signatures for? Which were easiest?”*
- *“Are there any that no one got initials for? Why do you think that was?”*
- *“Were there any questions you didn’t feel you could ask anyone, or felt uncomfortable asking? Why?”*
- *“Was there anything about doing this activity that surprised you?”*

Option B: “Stand Up If…” (10 minutes)

1. Tell the group that you are going to read a series of statements aloud, and that they should stand up when something you read applies to them. Explain that if a statement does not, they should simply stay seated.

2. Tell participants that they will not have to reveal the specifics pertaining to the question, and that it is up to them to decide whether they want to stand if a particular statement applies to them.

3. Using the facilitator’s resource, “Stand Up If…” choose statements depending on your group’s makeup (e.g., how well they know each other) and initial dynamics (e.g., whether they seem a bit reserved, or excited to be there).

Note to the facilitator: *You will not be able to do all of them, so be sure to begin with the least threatening statements first.*

4. Process the activity by asking the following questions:

- *“What did you notice about the experiences that people bring to this group? Were there more similarities or differences?”*
- *“What is something you learned, either about yourself or about the group as a whole?”*

- *“Why might we have used this activity to get us started?”*

5. Conclude by saying,

“We all bring with us our own experiences and beliefs from our own lives. That includes our values and beliefs about sex and sexuality. This influences how we see other people, and also how they see us – and it’s a good idea to keep that in mind as we move forward through this program.”

Ground Rules (15 minutes)

1. Ask the group, *“What can make it difficult to talk about sexuality in a group like this one?”*

Write down all answers on newsprint. Examples may include: it is embarrassing; people don’t want to sound like they don’t know enough/like they know too much; people are afraid of offending others, etc.

2. When the group has made an exhaustive list of things that can make talking about sexuality difficult, ask,

“What can we do to make this a safe and comfortable group for discussing sexuality? What ground rules should we set up?”

As participants make suggestions, write them on the newsprint. Allow the group to come up with as many rules as they can. If they do not agree on some, allow discussion about whether certain rules would enhance or hinder learning.

3. Be sure to raise the following ground rules/concepts if they are not contributed by the participants:

- **Confidentiality** – Whatever is said in this group remains here. When people choose to share something personal, it is a gift and should be treated as such.

Note to the Facilitator: *It is important to tell participants that as the facilitator, you don't want them to keep what the group talks about secret. In fact, the more they talk with their friends and family about it, the better. What is important, however, is that the group agrees not to share anything personal that someone in the group may share. Doing so would be disrespectful and unfair to that person. Instead, participants can simply say "I know someone who..." without identifying where they heard it. It is also important to tell participants that as the facilitator, you have a legal and moral responsibility that is greater than the rule of confidentiality. If you believe a participant's life or well-being is in serious danger because of abuse or a threat of suicide, you cannot keep that knowledge a secret.*

- **Right to Pass** – While group participation and discussion are important parts of this program, no one will ever be required to speak on any given issue. One can simply say, “I pass.”
- **No “Killer Statements”** – Put-downs are not acceptable. Participants need to respect one another.
- **Respect for Diversity** – As experienced in the last activity, participants come from different backgrounds and bring different experiences with us to this group. They are not going to agree on every subject or even most subjects. Everyone needs to respect one another's views, however, without trying to change or dismiss them.
- **Safety First** - It is important to be open and honest, but every member of the group needs to keep their own emotional safety and the privacy of others in mind during the sessions. That means it's a good idea for participants to think before sharing something personal if it's something they've never shared before. No one should disclose information about the private lives of family members, friends, neighbors, or others, unless they put it out as a general situation without names attached (e.g., “I know someone who...”).
- **“I” Statements** – This is basically another way of saying, “Own your own stuff,” rather than making generalizations. One way of doing this is by using “I” statements, like “I believe...” or “I feel...,” rather than, “All girls tend to be like this” or “Gay teens never think that way.”
- **No Direct Questions** – Participants should not be put on the spot by other group members asking direct personal questions. Questions like “Did you and [name] have

sex?” or “Have you ever had an STD?” are inappropriate. No personal questions should be directed between or to participants, or from or to the facilitator.

- **Right to invoke the ground rules** – It is the group’s responsibility, as well as the facilitator’s, to use and enforce the ground rules. Therefore, group members have a right to call one another on the rules when they feel one is being broken as much as the facilitator does.

***Note to the facilitator:** Doing ground rules with teens can take a lot of time, depending on whether there is agreement on what is contributed. It might be a good idea, therefore, to put a time limit up front, or to check in with the group at different intervals, remind them that the focus of the workshop is on STD prevention, and that the discussion is limiting the time for other topic areas. At the same time, it is important to avoid shutting down participants, so it may be best to come back to the ground rules during re-entry at the beginning of the next session.*

Goals and Program Values (15 minutes)

1. Tell the group that you would like to explain the major goals and values of the program. Post the goals and values that you wrote up on newsprint before the session and read through the list, allowing time to discuss each.
2. Tell participants that you would like them to try to keep these values in mind as you go through the sessions together. Emphasize that these program values do not, and should not, carry judgments with them. Explain that there is nothing wrong with having either a lot or very little knowledge about sexuality, that someone with more sexual experience is no better or worse than one with less experience, and that even though this program is specifically designed for LGBTQ young people, no one sexual orientation is better or more acceptable than any other.

How Susceptible Am I? (25 minutes)

1. Say, *"We are now going to do an activity that lets us look specifically at STD and HIV risk."*
2. Mix up the index cards you prepared before the session, and distribute one to each participant, along with a pen or pencil. Ask everyone to stand up and walk around until they find a partner. Once everyone finds someone to partner with, ask them to sit down.

***Note to the facilitator:** It is fine to have one group of three with an odd-number group.*

3. Say,

"I am going to ask you to have a brief conversation together, but I'm going to give you the topic. The question is, 'What do you think puts you and other LGBQ teens at risk for STDs?' Go ahead and discuss it; I'll let you know when time is up."

4. When a minute is up, ask everyone to sign their partner's card and to return the card to that person. Ask the group to stand up again and walk around the room until they find another partner to sit down with.

5. As described above, give the partners one minute to discuss a new discussion topic:

"What do you think the greatest challenge is to talking about safer sex with a sex partner?"

6. After another minute, ask participants to sign their partner's card, and return the card to their partner. Ask the group to stand up, walk around one more time, and select a new partner.

7. As described above, ask partners to sit down and discuss the following question for one minute:

"If you found out that a close friend of yours had contracted an STD, what would you say or do?"

8. After one minute, have everyone sign their partners' cards, return them to the other person, and return to their seats with their original index card.

9. Say,

“For the purposes of this activity ONLY, what you just had were not conversations – they were sexual encounters. And if you’ll look on the back of your index cards, you may see a small letter written in the lower right-hand corner.”

10. Ask the participants with the letter “S” written on the back of it to stand up. Say,

“Again, for the purposes of this exercise only, we’re going to pretend that the “S” means that this person is infected with an STD.”

11. Ask,

“If you have the signature of any of the people standing on your card, could you please stand up?”

Once they have stood up, say the following:

- *“This is only for those people who are standing. If you have the letter “U” written on your card, you had some kind of unprotected sex with one of the people who is standing up. That means you were exposed to an STD, and may now be infected, so you need to remain standing.”*
- *“Again, only for the people who are standing -- if you have the letter “D” on your card, you were drinking a lot of alcohol or using drugs and have no memory of what happened that night. That means, you could have been infected, so you should remain standing.”*
- *“If you are standing up and have the letter “L” on your card, you used some kind of latex barrier during sex and significantly reduced your chances of getting an STD – so you can sit down.”*

● *“If you have the letter “A” on your card, you chose to abstain from any high-risk sexual behaviors – those that involved the exchange of semen, vaginal fluids, or blood -- and can sit down.”*

12. Ask, *“Who has the signature of any of the people who are now standing up?”* Ask those people to stand up and go through what each of the letters means as above. Continue this process for three (for a smaller group) or four (for a larger group) rounds.

13. Ask the group to remind you of how many people were standing at the very beginning – the ones who had the “S” on their cards – and compare that to the number of people who are standing now. Have everyone sit down.

14. Process the activity by asking the following questions:

- *“What was it like to do this activity? What was [participant response] about it?”*
- *“How did it feel to discover you had been exposed to or infected with a sexually transmitted disease?”*
- *“For those of you who were asked to sit down, how did that feel?”*
- *“What does the larger number of people who were standing at the end tell you about STD transmission and prevention?”*

15. Conclude the activity by saying,

“This activity was designed to demonstrate the phrase, ‘When you have sex with someone, you are having sex with everyone they ever had sex with.’ In this game, people were infected at random. In real life, however, people have control over their behaviors and can make choices that will reduce their risks for STDs, including HIV. This activity also serves as a reminder that we are all vulnerable to STDs – so we all must take precautions to protect ourselves and our partners.”

How Do I Feel About This Issue? (40 minutes)

1. Tell participants,

“The issue of STD prevention is not only about facts and statistics. It is also about people’s attitudes, values and beliefs. Even though this is a group that has come together because of identifying as either lesbian, gay, bisexual, or queer, it doesn’t necessarily mean that everyone in the room feels the same way about all of the issues we are talking about in this program. This next activity will give you a chance to think about your own values and beliefs and to hear different points of view you may not have considered before.”

2. Point out the signs you placed in a continuum across the room, titled, “Strongly Agree,” “Somewhat Agree,” “Somewhat Disagree,” and “Strongly Disagree.”

Note to the facilitator: *Depending on the set up of the room the signs can either be placed along one wall of the room or in a line across the floor.*

Explain that you are going to read a series of statements and that they are to decide, without discussion, what they believe and then stand along the part of the continuum that represents their belief, from Strongly Agree all the way to Strongly Disagree. Offer the following guidelines for the activity:

- *“There are no right or wrong answers. These are opinions we’re discussing, not factual information.*
- *You have to respond to the statement the way it’s read – I’m not going to clarify what is meant, or answer ‘what if’ questions. Just go with what you hear.*
- *Once you choose your position, several of you will have the chance to explain why you chose to stand where you did. This is not a debate – you’re not trying to convince anyone to change their minds. You’re simply explaining why you’re standing where you*

are. You can certainly ask someone to clarify something they've said if it's not clear, but if it becomes a debate, I'm going to jump in and direct us back to just expressing our viewpoints. At the same time, if you do hear something that makes you want to change where you stand, you can change your position at any time.

- *Since we're talking about values and beliefs, please keep the ground rules in mind, especially when it comes to respecting differences."*

3. After answering any questions about the instructions, read a statement aloud, reminding participants to stand on the part of the continuum that most closely fits their opinion about the statement.

Note to the facilitator: *When conducting a values clarification activity like this, it is important to avoid sharing your own values and beliefs. Even if you do not verbally express them, there are ways of communicating your feelings non-verbally. To avoid doing this, we offer the following suggestions:*

- *Read each statement two or three times, looking at the paper the entire time. This will keep you from making eye contact with participants and possibly revealing approval or surprise in response to where they stand.*
- *Try to avoid smiling in response to a particular statement, or nodding your head. While these non-verbal gestures are often used to simply express that we are listening to or understand someone, within the context of this activity, they can also communicate approval or disapproval with a particular point of view.*

4. Once everyone has chosen where to stand, ask for several volunteers to explain why they are standing where they are. Be sure to ask for contributions from different places on the continuum.

5. Continue through the rest of the statements, completing as many as time will allow. Let the discussions continue if participants are clarifying values, or discussing opinions in a productive way.

6. Process the activity using the following questions:

- *“What was it like to do this? What was [participant response] about it?”*
- *“For which statements did you think it was particularly challenging to take a stand? Why?”*
- *“Did your thinking about any of these issues change in any way? In what way?”*
- *“What did you learn about yourself from this activity that will help you in protecting yourself from STDs/HIV?”*

Closure (5 minutes)

1. Tell the group that you are now at the end of the first session with five to go, and that you would like to check in about how people are feeling about the program so far.
2. Ask participants to each share, in no particular order, to say either one new thing they learned during today’s session or one thing that they found really surprising, reminding them of their right to pass.
3. Once everyone has gone, thank the group for their participation today and remind them about the time for the next session.

Handouts/ Facilitator Resources

SESSION ONE

Program Goals

To help lesbian, gay, bisexual, and queer teens to:

- Increase their knowledge about STDs, including HIV.
- Recognize that STDs are a viable risk to them and that it is desirable to avoid them in order to be sexually healthy.
- Recognize that they are able to protect themselves from STDs, including HIV.
- Build skills they need to avoid STDs.

Program Values

In this program, teens have the right to:

- Ask any questions they may have about sexuality and STD/HIV prevention.
- Receive full and accurate information.
- Seek and receive support in making decisions about sexual matters.
- Express their sexuality in ways that they feel are healthy and affirming for them.
- Be treated with respect, dignity and fairness by the facilitator(s) and other participants in this program.
- Expect that no assumptions will be made by the facilitator(s) regarding their sexual orientation, their level of sexual activity or experience, or their values or beliefs.

Find Someone Who...

1. Has ever seen a speaker present about STD prevention _____
2. Has traveled outside of the United States _____
3. Can stand on one foot for five seconds _____
4. Can recite the first 3 lines of any poem _____
5. Is the youngest child in a family _____
6. Considers her/himself to be very spiritual _____
7. Can name three STDs _____
8. Has been out for more than a year _____
9. Was raised by a single parent _____
10. Can raise one eyebrow _____
11. Knows who Harvey Milk was _____
12. Knows where s/he wants to be in 5 years _____
13. Feels that s/he is a good dancer _____
14. Believes s/he knows all s/he needs to about sexuality _____
15. Has a friend with HIV disease or AIDS _____
16. Watches a lot of television _____
17. Is out to her/his parent(s)/caregiver(s) _____
18. Knows any American Sign Language _____
19. Can name an LGBTQ s/hero _____

Stand Up If...

- You grew up in the Western US... The Midwest... The South... The Northeast... Outside of the United States...
- You grew up in a city... On a farm... In a suburb...
- You wish you were taller... shorter... are perfectly happy with your height...
- You wish you were older... younger... are happy with the age you are...
- You identify religiously as Catholic... Protestant... Jewish... Agnostic... Buddhist... Hindu... Muslim... Quaker... Atheist... Lutheran... Born Again... anything else I didn't mention...
- You have ever lived with a temporary physical disability... with a permanent physical disability... with a developmental disability...
- You have come out to at least one member in your family...
- You have ever done something in your life that put your health or life at risk...
- You have ever felt different from other people...
- You have ever wished you could be a different sex or gender...
- You have ever wished you could be a different sexual orientation...
- You come from a large family... a small family... are the only child in your family...
- You have ever had a teacher with whom you just couldn't connect...
- You enjoy having friends who are different from you...
- You have had any kind of sexuality education in school...
- Your parents or other family members have ever talked with you about sexuality...
- You have ever felt at a disadvantage because of your gender...
- You have ever felt discriminated against because of your gender identity or sexual orientation...
- You have ever had other people mistake your gender or sexual orientation...
- You have ever done something of which you were extremely proud...

Values Voting Statements

***Note to the facilitator:** Feel free to add statements or delete them depending on the group. If there are particular issues that you know this group wants or needs to work on, adding statements that encourage discussion of those issues would be an appropriate way to tie the lessons together.*

- Making everyone get tested would be a good way to reduce STD transmission in this country.
- Medical professionals should be allowed to decide for themselves whether or not they want to treat someone infected with HIV.
- Sometimes it's okay to lie to someone about being infected with an STD.
- Someone who is infected with HIV should never have sex again.
- A person who is infected with HIV and knowingly exposes someone else to it should be sent to prison.
- Women or girls infected with HIV should not get pregnant.
- If you get infected with HIV, you are the only one to blame.
- It is not as much of a big deal having an STD/HIV among LGBTQ people because it is just sort of expected.
- With all the information out there about latex, someone who has unprotected sex deserves to get an STD or HIV.
- Being closeted makes it harder to deal with having an STD or HIV.
- Because of bias and discrimination, it is harder for LGBTQ teens to go to a doctor or clinic to get treated for an STD.
- Sometimes, there are good reasons to allow yourself to get an STD, including HIV.
- Abstaining from any kind of sex to avoid STDs is a totally unrealistic expectation of LGBTQ teens.
- Avoiding HIV and STDs is a lot harder for LGBTQ teens than it is for heterosexual teens.

SESSION TWO

“WELL, WADDYA KNOW?”

RATIONALE:

Factual information about STDs, including HIV, is essential to helping young people make healthy choices and avoid infection. In particular, it is important to clarify myths participants may have that may keep them from acting in the best interest of their health. Because HIV is the most well-known and worrisome STD for many, particular attention needs to be paid to the information and myths about this virus. Finally, it is important for participants to have a good understanding of what is involved with testing, including the benefits of getting tested for STDs/HIV if they have engaged in any behaviors that may have exposed them to infection. To reinforce this concept for themselves and for one another, participants will be asked to develop advertisements encouraging teens like themselves to get tested.

TIME:

2 hours

GOALS:

To help participants to:

- Increase their awareness of the similarities and differences among various STDs.
- Increase their understanding of transmission, treatment, prevention, and testing issues related to common STDs.
- Differentiate between myths and facts related to HIV.
- Increase their understanding of the issues related to STD and HIV testing.

OBJECTIVES:

By the end of this session, participants will be able to:

- List at least five similarities among the top six STDs.
- Provide factual information that will correct at least five common myths about HIV.

- Name at least two reasons why young people choose not to be tested for STDs/HIV and an effective rebuttal to each of those reasons.

MATERIALS:

- | | |
|---------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Blank newsprint pad | <input type="checkbox"/> Facilitator resource: Myths and Facts about HIV |
| <input type="checkbox"/> Newsprint markers | <input type="checkbox"/> Handout: List of Web sites for more information on STDs and HIV |
| <input type="checkbox"/> Masking tape | |
| <input type="checkbox"/> STD information handouts | |

ADVANCE PREPARATION:

1. At the top of five sheets of newsprint, write one of the following STD names: Syphilis, Gonorrhea, Herpes, Chlamydia, Human Papilloma Virus.
2. On a single sheet of newsprint, write “Questions about STDs” at the top, and the following questions beneath:
 - How could I get it?
 - How could I avoid getting it?
 - What are the symptoms?
 - How could I get tested for it?
 - How is it treated? Is it curable?
 - What could happen if it weren’t treated?
3. Prepare two sheets of newsprint, one of which should have the heading, “Reasons why young people don’t get tested for STDs/HIV” and another marked, “Good reasons for young people to get tested.”

PROCEDURE:

Re-entry (10 minutes)

1. Welcome participants back to the second session.

2. Ask group to go around and finish the sentence stem, “Thinking about being here today, I feel...” Acknowledge the range of feelings/comfort levels in the group.
3. Ask whether there are any questions or comments from the last session before the group gets started on the new session.

STD Myths and Facts (15 minutes)

1. Introduce this segment by saying,

“There is a lot of information -- and misinformation -- out there about sexually transmitted diseases, including HIV. We’re going to spend a little time now going over what you have heard and figuring out what are myths, what are facts, and what we just don’t know.”

2. Break participants up into small groups of no more than 3-4. Provide each small group with a blank sheet of newsprint paper and a marker.
3. Tell participants that when you say “go,” they are to brainstorm onto the newsprint sheet ten things they have heard about STDs. Tell them not to worry if they’re not sure if what they’ve heard is correct or incorrect, they should simply try to come up with ten things. Let them know that the first group to come up with ten things should raise their hands and the activity will stop. If there are no questions about the instructions, say, “Go!”
4. Once one group has come up with and recorded ten things, stop the rest of the groups. Have the winning group come to the front of the room, post their newsprint sheet, and read off their list of things they have heard about STDs, one at a time. Once their list is complete, ask the other groups to add items from their lists that have not already been mentioned. Record these on the first group’s newsprint sheet at the front of the room, until all lists have been read and there is one comprehensive list in front of the group.

5. Note with the group how much different information exists about STDs and HIV. Explain that while they may be able to recognize some of them right away as being true or not true, others may be more difficult to determine. Let them know that they are going to do some research to get some specific information and answers to questions about some of the most common STDs, and that you will be coming back to the large list you made at the front of the room before the end of the session.

Facts about STDs (40 minutes)

1. Divide participants into five small groups, making sure there are at least two people in each group.

2. Once they are in their small groups, let participants know that you are going to come around with a newsprint sheet that has a particular STD on it, and a fact sheet about that STD. Instruct them to go through the material you provide and list the answers to the following questions about their STD on their newsprint (reveal the prepared newsprint sheet titled, “STD Questions”, and read them aloud):

- How could I get it?
- How could I avoid getting it?
- What are the symptoms?
- How could I get tested for it?
- How is it treated? Is it curable?
- What could happen if it weren't treated?

Let them know they have only about 15 minutes in which to do this.

3. As the groups work, go around to make sure they don't have any questions or need any help. After about 15 minutes, call time.

4. Have the small groups post their newsprint sheets on the front wall and ask someone from each group to read the information. Be sure to clarify any information as you go along. Once everyone has gone, ask

“What themes or similarities did you notice throughout the presentations?” Probe for:

- *STDs caused by viruses -- HIV, HPV, Herpes, and Hepatitis B -- are not curable. Medical treatment can, however, alleviate the symptoms of these STDs.*
- *The bacterial STDs, which include Gonorrhea, Syphilis and Chlamydia, are all curable with antibiotics.*
- *Using latex barriers reduces the risk of getting or transmitting just about every kind of STD.*
- *Any of these STDs can be present in someone’s body without that person knowing it.*
- *If someone has one of these STDs, they can transmit it to someone else even if they don’t have any symptoms.*

5. Return to the list of information that the groups generated in the first activity. Say,

“Now that you’ve done some research about several STDs, are there some statements here that are definitely myths that can be crossed off?”

Note to the facilitator: *Because you are about to do a separate piece on HIV, let them know that you are going to pass over any statements about HIV and come back to them in the next activity. Go over each statement, one by one, and ask the group if the statement is a myth or a fact. If they recognize a myth, cross off the statement and ask whether anyone knows a fact that would relate to it. For example, “You can tell who has an STD by looking at someone” is a myth. A related fact is that the most common STD symptom is no symptom. As you go through, provide additional information as appropriate and indicate, when appropriate, topics that will be touched upon in more depth later in the program. Continue this process until all of the statements have been read and categorized as myths or facts.*

Note to the Facilitator: *Participants may come up with myths or facts with which you are unfamiliar and are unable to identify as myth or fact. This is perfectly fine. There is so much information and misinformation (much of which seems quite plausible) about STDs that it is*

impossible to know all the information. If you are unable to identify a statement as a myth or fact, say so. Perhaps ask if someone would like to volunteer to find out the correct information and to report back to the group at the beginning of the next session. You can follow up and do the same.

Myths and Facts About HIV (25 minutes)

1. Explain to the group that because HIV receives so much more attention, and is usually considered the most dangerous STD, you want to devote some extra time to exploring it in more detail.
2. Divide the participants into groups of four. Tell groups that they are going to be exploring myths and facts again, only this time, they will be about HIV ONLY – and that this time, they’re going to play a game. Explain that you will share a common myth about HIV, and they will have to provide the fact. For each correct fact their team can name, their team will receive a point. The object is to get as many points as possible. The team with the most points at the end is the winner.
3. Ask each group to pick a spokesperson. Explain that after the myth is read, the team will be able to discuss their answer together for a few seconds, but that only the spokesperson will be allowed to give the answer to the facilitator. If a team does not answer correctly or provide sufficient information, the next team in line will have the opportunity to earn the point by answering correctly.
4. Using the facilitator resource, “Myths and Facts about HIV,” read through as many myths as time allows, having each group answer in turn, and awarding points to correct answers.
5. Acknowledge the good work of all the groups, while recognizing the group that ended up winning the game. Let participants know that there is one topic area pertaining to STDs that you still want to cover before you break for the day: testing.

Testing (20 minutes)

1. Using the facilitator resource, “STD and HIV testing,” provide a brief overview of STD and HIV testing issues to participants.
2. Reveal the newsprint sheet, “Reasons why young people don’t get tested for STDs/HIV.” Ask participants to come up with ideas and record them on the sheet. Possible responses may include:
 - They don’t really think they are at risk.
 - They don’t want to know if they are infected.
 - They are embarrassed.
 - They don’t know where to go to get tested.
 - They are afraid.
 - They don’t want anyone to find out.
 - They don’t want their parents to know.
3. Next, reveal the newsprint sheet that reads, “Good reasons for young people to get tested for STDs/HIV.” Again, record their responses on the sheet. Possible responses may include:
 - Many STDs have no symptoms, but can cause serious harm if left untreated.
 - If they have an STD they can get it treated.
 - If they are infected with an STD they need to tell their sex partner(s).
 - The sooner they have it treated the better the health outcomes.
 - It is no different than having any other kind of infection.
4. After both lists have been completed, go over each reason on the first list and ask the group, *“Which reasons for getting tested on the second list would be effective rebuttals for each reason you listed on the first list ‘Why people do NOT get tested?’”*

For example if a reason why young people don’t get tested is “they don’t really want to know if they are infected,” a good rebuttal from the other list might be “If they have an STD they can get

it cured (bacterial STDs) or treated (viral STDs).” If there is no rebuttal on the second list that applies to the first list, ask participants to come up with one that they think would make a compelling argument.

Closure (10 minutes)

1. Go around the group and ask participants to share one thing they learned today that they think they would like to share with a friend.
2. Say,

“ We covered a lot of information today. It’s important to know the basics about STDs and HIV in order to be able to make healthy decisions and take action to keep yourselves STD- and HIV-free. Don’t worry if you don’t remember all of the facts from today. There are lots of places where this information is available. And, if you want even more information about a particular STD that we talked about today, or one we didn’t really talk about, or about testing, it’s good to know where these resources are.”

3. Provide participants with the list of Web sites for resource information on STDs and HIV.
4. Thank the group for participating in today’s session. Remind them of the time and place for session three.

Handouts/ Facilitator Resources

SESSION TWO

Facts about Syphilis (SIF*F*-i-lis)

from Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

Syphilis is caused by a bacterium called a spirochete. It is usually spread by sexual contact, including penis-vagina, penis-anus, and oral sex, but it can also be spread by kissing or by a pregnant woman to the fetus growing inside her. It is sometimes called “syph,” “pox” or “bad blood.” There are 70,000 new cases each year in the U.S. The incidence of Syphilis has been on the rise particularly among men who have sex with men.

Common symptoms

Syphilis has several phases that may overlap one another. They do not always follow in the same sequence. Symptoms vary with each phase, but there are no symptoms most of the time.

- **Primary Phase:** Painless sores or open, wet ulcers — chancres — often appear from three weeks to 90 days after infection. They last three to six weeks. They appear on the genitals, in the vagina, on the cervix, lips, mouth, or anus. Swollen glands may also occur during the primary phase.
- **Secondary Phase:** Other symptoms often appear from three to six weeks after the sores appear. They may come and go for up to two years. They include body rashes that last from two to six weeks — often on the palms of the hands and the soles of the feet. There are many other symptoms, including mild fever, fatigue, sore throat, hair loss, weight loss, swollen glands, headache, and muscle pains.
- **Latent Phase:** No symptoms. Latent phases occur between other phases.
- **Late Phase:** One-third of untreated people with syphilis suffer serious damage to the nervous system, heart, brain, or other organs, and death may result.

If syphilis is untreated, it can lead to brain damage, heart disease, deafness, blindness, and possibly death in 40 years. A pregnant woman who has syphilis can pass it to her fetus.

Syphilis can be cured with antibiotics. Damage to internal organs during the later stages, however, is irreversible. If people choose to have sex, they should always use latex barriers.

Syphilis is especially contagious when sores are present early in the disease — the liquid that oozes from them is very infectious. People are usually not contagious during the latent phases of the first four years of syphilis infections.

Testing: The test for syphilis is a blood test or a swab sample from a lesion.

Protection: Latex barriers reduce the risk of infection with syphilis during sexual behaviors.

Facts about Herpes

from *Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I*, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

There are two forms of genital herpes — herpes simplex virus-1 and herpes simplex virus-2. Although herpes-1 is most often associated with cold sores and fever blisters, both forms of herpes may be sexually transmitted. In fact, most adults have herpes simplex virus (HSV), either type 1 or type 2, or both. During pregnancy, herpes may cause miscarriage or stillbirth.

More than 45 million Americans have been diagnosed with genital herpes. At least one million new cases are diagnosed every year. Like many other viruses, HSV remains in the body for life. Transmission from woman to woman very likely occurs, but data on specific prevalence and risks is very limited. In particular, oral sex can transmit Herpes Simplex Virus 1 from the mouth to the genitals, especially when one partner has a cold sore. Herpes can be spread even if there is no open sore.

Common symptoms

- a recurring rash with clusters of itchy or painful blistering sores appearing on the vagina, cervix, penis, mouth, anus, buttocks, or elsewhere on the body
- painful ulcerations that occur when blisters break open
- pain and discomfort around the infected area, itching, burning sensations during urination, swollen glands in the groin, fever, headache, and a general run-down feeling

Symptoms usually appear from two-20 days after infection — but it may be years before an outbreak occurs. Recurrences are sometimes related to emotional, physical, or health stresses. If a person has genital herpes, the first sign is usually a tingling or itching in the genital area, followed by painful blisters that break open into sores. Sometimes, genital herpes may go unnoticed; on women, because the blisters occur on the cervix inside the vagina. Both males and females may have flu-like symptoms, including fever, aching joints and a general ill feeling.

How HSV is spread

- touching, sexual intimacy — including kissing
- penis-vagina, penis-anus, and oral sex

Protection: Partners should refrain from sexual intimacy from the time they know the blisters are going to recur until after the scabs have completely fallen off the healed sores. Sores do not need to be there to pass the virus. People without sores also may pass the virus to another person during sex. Latex barriers reduce the risk of transmitting the virus between outbreaks.

Testing: The test for herpes is a blood test, although most blood tests cannot distinguish between types of herpes. A swab test can also be done.

Treatment: Genital herpes *cannot* be cured. Symptoms can be relieved and the number of recurrences reduced with the drugs valacyclovir, acyclovir, and famciclovir.

Facts about Gonorrhea

from Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

Gonorrhea is a bacterial infection that can cause sterility. It is passed through penis-vagina, penis-anus, and oral sex. Other names for gonorrhea are “the clap,” “the drip” or “a dose.”

Common symptoms

- for women: frequent, often burning, urination; menstrual irregularities, pelvic or lower abdominal pain; pain during vaginal penetration or pelvic examination; a yellowish or yellow-green discharge from the vagina; swelling or tenderness of the vulva; and even arthritic pain.
- for men: a pus-like discharge from the urethra or pain during urination

Eighty percent of the women and 10 percent of the men with gonorrhea show no symptoms. If they appear at all, symptoms occur in women within 10 days. It takes from one to 14 days for symptoms to appear in men.

Symptoms appear between 2 days and 3 weeks after infection. Untreated gonorrhea can lead to severe infection of the reproductive system, skin disease and joint problems. A mother can infect a newborn with gonorrhea during birth. In women, gonorrhea can cause pelvic inflammatory disease (PID).

Treatment

Gonorrhea can be cured with oral antibiotics. Often people with gonorrhea also have chlamydia. They must be treated for both infections at the same time.

Testing: The test for gonorrhea might be a urine test, a blood test, or a swab test.

Protection

Latex barriers reduce the risk of infection with gonorrhea.

Facts about Chlamydia

from Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

Chlamydia is one of the most common STDs in the United States. It is a bacterial infection that is passed through sexual contact, including penis-vagina sex, penis-anus sex, and perhaps oral sex. It can cause sterility in women and men. In women, it infects the cervix and can spread to the urethra, fallopian tubes, and ovaries. It can cause bladder infections and serious pelvic inflammatory disease, ectopic pregnancy, and sterility. In men, chlamydia infects the urethra and may spread to the testicles, causing epididymitis, which can cause sterility.

Common symptoms

- discharge from the penis or vagina
- pain or burning while urinating, frequent urination
- excessive vaginal bleeding
- painful vaginal penetration for women
- spotting between periods or after intercourse
- abdominal pain, nausea, fever
- inflammation of the rectum or cervix
- swelling or pain in the testicles

Symptoms appear in seven to 21 days — if they appear. Seventy-five percent of women and 50 percent of men with chlamydia have no symptoms. Many women discover they have chlamydia only because their partners are found to be infected.

If untreated, the infection can spread and cause permanent damage to the reproductive system, including sterility. Chlamydia can be passed to babies during birth.

Chlamydia can be cured with antibiotics.

Chlamydia can also lead to reactive arthritis — especially in young men. One in three men who develop reactive arthritis become permanently disabled. In infants, chlamydia can cause pneumonia, eye infections, and blindness. Chlamydia is the most common and most invisible sexually transmitted bacterial infection in America. At least three million American men and women become infected every year.

Testing: The test for chlamydia is either a urine test or a swab cell culture.

Treatment: People can be treated successfully with antibiotics. Follow-up testing may be suggested three to four months after treatment.

Protection: Latex barriers reduce the risk of infection with chlamydia.

Facts about Human Papilloma (pap-ill-LOW-mah) Virus (HPV)

from Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

There are over 100 strains of the Human Papilloma Virus (HPV). Some cause genital warts, but most genital HPV infections are not visible and have no symptoms. Some of these cause abnormal cells to grow on the cervix, which can lead to cervical cancer. Every year, more than five million Americans are newly infected with genital HPVs — about 20 million are now infected. HPV is transmitted by penis-vagina, penis-anus, and oral sex, as well as by direct skin-to-skin contact with an infected individual. It can also be transmitted when warts are not present. HPV can be easily transmitted from a woman to her female partner because HPV only requires skin-to-skin contact and so, unlike some other STDs, is commonly found among women who have sex with women.

Common symptoms

- Warts appear on the genitals, in the urethra, in the anus, and, rarely, in the throat.
- Genital warts are soft to the touch, may look like miniature cauliflower florets, and may or may not itch. Untreated genital warts can grow to block the openings of the vagina, anus, or throat and become quite uncomfortable.
- It usually takes two to three weeks after infection for warts to develop. Genital warts grow more rapidly during pregnancy or when other infections are present.
- If left untreated, genital warts may disappear. However, HPV infection remains and warts can reappear.
- Many HPV infections do not cause warts and have no symptoms at all.

Treatment:

There is no cure for HPV. There are, however, a number of methods to remove warts. They may be removed by carefully applying, and often reapplying, a prescription medication — podofilox or imiquimod — to the wart. Clinicians offer other treatments, including laser surgery (vaporizing the wart with a beam of high-powered light), cryosurgery (freezing the wart with liquid nitrogen), injecting interferon into the warts, and more.

Protection and Prevention:

A Pap test is a routine gynecological test in which a health care provider uses a cotton swab or similar instrument to collect cells from the cervix. The test looks for abnormal or precancerous cells. These cells may be signs of cervical cancer. Regular Pap tests reduce the risk of invasive cervical cancer by early detection of abnormal cells. In fact, over half of women newly diagnosed cervical cancer had not had a Pap test in 5 years. In men, HPV is often diagnosed visually when genital warts are present.

Latex barriers reduce the risk of genital warts and cervical cancer, but the virus may "shed" (and therefore, be transmitted) beyond the area protected by the latex.

Facts about Hepatitis B (hep-ah-TIE-tis)

from Safer Choices: Preventing HIV, Other STD and Pregnancy, Level I, Coyle K and Fetro, J (1998) ETR associates, Santa Cruz, CA and Planned Parenthood Federation of America; accessible on-line at www.plannedparenthood.org

Hepatitis B virus (HBV) is a common STD that can be prevented with vaccination. About 78,000 Americans get HBV every year because they have not been vaccinated. According to the CDC, it is estimated that 1.25 million people in the United States have chronic HBV. Chronic (long-lasting) hepatitis B can cause liver cell damage, which can lead to cirrhosis (scarring of the liver) and cancer.

How HBV is spread:

- in semen, saliva, blood, and urine (HBV has also been found in low concentrations in other body fluids, though these fluids have NOT been associated with transmission)
- by intimate and sexual contact, from kissing to penis-vagina, penis-anus, and oral sex
- through using contaminated needles to inject drugs (from sharing needles with other injectors)
- from accidental sticks with contaminated needles in the course of health care
- by sharing personal hygiene utensils such as toothbrushes and razors

Transmission between female partners has not been studied, but has occurred.

Although 90-95 percent of adults with HBV recover completely about five to ten percent of people who get HBV as adults will be "carriers" and have chronic (long-term) infection with HBV. Chronic HBV infection can cause severe liver disease and death. Unless they are treated at birth, 90 percent of the infants born to women with HBV will carry the virus. Pregnant women who may have been exposed to HBV should be tested before giving birth so that their babies can be vaccinated at birth or treated if they become ill.

Common symptoms

- extreme fatigue, headache, fever, hives
- lack of appetite, nausea, vomiting, tenderness in the lower abdomen
- later symptoms: more abdominal pain, dark urine, clay-colored stool, yellowing of the skin and white of the eye — jaundice
- HBV may be invisible during its most contagious phases.

Testing: The test for hepatitis is a blood test.

Treatment: In most cases the infection clears within four to eight weeks. Some people, however, remain infected and contagious for the rest of their lives.

Protection: Latex barriers offer some protection against hepatitis during penis-vagina, penis-anus, and oral sex, but the virus can be passed through kissing and other intimate touching.

HIV Myths and Facts

Directions: Below are some common myths and the related facts about HIV/AIDS. Read the myths statements one at a time while teams will take turns correcting the myth by providing the related factual information. If a team does not know the correct fact, the next team in line will have the opportunity to answer. Since some of the facts are longer and more complicated than others, the facilitator will be the final judge as to whether sufficient information was provided. A correct response earns a team one point.

Myth: All sexual activity with an infected person should be considered risky for HIV transmission.

Fact: There are pleasurable and safe alternatives to high-risk sexual behaviors, including mutual masturbation, kissing, dry-humping, phone sex, role play, and more. And if a couple is going to have penis-vagina, penis-anus, or oral sex, they should use latex barriers each and every time.

Myth: Once a person contracts HIV, he/she will begin to get sick within 6 months to a year.

Fact: While some people who contract HIV do begin to show symptoms relatively quickly—especially people who already have poor immune systems -- people can have HIV for years without having any symptoms. This is particularly true of people who take care of their health, adhere to medication schedules, and more.

Myth: There are a few cases of people, like Magic Johnson, who have been cured of HIV.

Fact: There are people who have been taking drug regimens in whom the viral load is so low, it has become “undetectable.” That does not mean, however, that the virus has been cured. Once HIV is in the body, it’s in the body for life. If a person were to stop taking his/her medications, the viral load would go right back up. Even if a viral load is low, an HIV+ person can still transmit the virus to someone else.

Myth: Women who only have sex with other women cannot become infected with HIV.

Fact: If a woman has intimate sexual contact with another woman who is infected with HIV, she is at risk. HIV can be passed through vaginal secretions and blood, including menstrual blood. There have been documented cases of female to female sexual transmission of HIV.

Myth: If I don’t have anal sex, I won’t get infected.

Fact: Penis-anus sex without a condom is very high risk for infection because of how the rectum is made. But unprotected penis-vagina and oral sex are also risky for HIV transmission. HIV can be absorbed through the tissues of the vagina, the rectum or the mouth. If the blood, semen or vaginal fluids of an infected person get into another person’s body, HIV can get in, too.

Myth: A healthy-looking partner is a safer partner.

Fact: Many people with HIV have absolutely no symptoms, and may not even be aware that they are infected.

Myth: HIV is contagious. That means it's easy to get.

Fact: Unlike colds or the measles, HIV cannot be transmitted through ordinary public contact. That includes sneezes, coughs, hugs or shaking hands; using toilet seats, drinking fountains, public phones or swimming pools; and touching objects or eating food handled by someone who is infected. Not a single case has been found where a person got HIV through casual contact, even when they lived with or worked with or went to school with someone who was infected. You can only catch the virus by getting the blood, semen or vaginal fluids of an infected person inside you. (Note: Breast milk is also a risky body fluid.)

Myth: Since there is no cure for HIV there is no need to get tested.

Fact: Although there is currently no cure, there are new treatments that slow the spread of HIV in the body, which can help the immune system keep strong so it can fight off other health-related problems. Knowing one's HIV status is the only way to know whether treatment is needed.

Myth: Abstinence is the only way to be safe. Condoms break all the time.

Fact: Abstinence (not having penis-vagina, penis-anus, or oral sex) will protect a person from catching HIV, if they don't share injection drug equipment or unsterilized needles. But for people who do have some kind of sex, latex barriers are their best protection – as long as they are used consistently and correctly.

Myth: The top partner during penis-vagina and penis-anus sex is at low risk for HIV.

Fact: In reality, someone who puts a penis inside another person is at high risk of infection; the person who is having a penis put inside their anus or vagina is at even higher risk of infection. This is because the insertive partner is being exposed to his partner's anal secretions and, possibly, some blood during anal sex. He is also being exposed to his partner's vaginal secretions and possibly menstrual blood during penis-vagina sex. HIV can enter his body through microscopic cuts/abrasions on the head of his penis that normally occur during intercourse. He can also get infections inside the urethra, the tube through which semen and urine leave the body. During unprotected penis-vagina and penis-anus intercourse, the insertive partner (the top) is at high risk, and the receptive partner (the bottom) is at even higher risk. Neither partner is at low risk. The same holds true for other STDs as well.

Myth: Having another STD does not make a person more likely to contract HIV.

Fact: Having an STD that causes open lesions (like syphilis and herpes) can further increase this risk. Having another STD also depletes the immune system, which makes fighting HIV as well as other infections difficult. The weaker the immune system is, the faster HIV can replicate and continue to harm the body.

Myth: Oral sex is low risk for HIV.

Fact: *Receiving* oral sex (exposure only to saliva) is very low risk for HIV. But *performing* oral sex (exposure to pre-cum, semen, vaginal secretions and menstrual blood) is risky for HIV. The more of these body fluids that a person gets into his/her mouth, the greater the risk. For example, when performing oral sex on a penis, HIV can be transmitted through pre-cum or ejaculate. The risk is lower than through penis-vagina or penis-anus sex, but the risk is real. Plus, a person is at risk for all the other STDs out there through unprotected oral sex.

Myth: The number of people who are either infected with HIV or who have AIDS is going down.

Fact: Actually, just the opposite is true. The number of people who are infected with HIV is going up. Better treatments are keeping people healthier and living longer, thus slowing down the progression from HIV infection to AIDS, and also reducing the death rate from AIDS.

Myth: You can contract HIV if you get another person's semen/cum or vaginal fluids on your skin.

Fact: Kissing, mutual masturbation, and getting another person's semen/cum or vaginal fluids on your skin do not spread HIV. HIV cannot enter through the skin unless there is a fresh break in the skin. There is no scientific evidence that HIV is passed through saliva, tears, or sweat.

Myth: There is no real way to protect yourself during oral sex on a vulva (cunnilingus) or oral-anal sex (rimming).

Fact: There are a number of options. A latex condom can be cut open and stretched over the vulva or anus. Dental dams (latex squares) can also be used; they are available in medical supply stores and from some adult shops. They are also available at some health clinics, so be sure to ask! Some people find it easier to use a sheet of plastic wrap. The more that is used, the more coverage (and protection) there will be.

Myth: Infection rates among young gay men have been on the decline for the past several years.

Fact: Infection rates for gay men continue to escalate, especially in communities of color and among young people. There are a number of different factors that may come into play, including a lack of information about how HIV is transmitted, less access to healthcare services (or a greater level of stigma around accessing healthcare), the perception that HIV is not as serious as it used to be, and therefore risky behavior is once again acceptable, and more. But gay men are certainly not the only ones at risk. *Any person who has unprotected penis-vagina, penis-anus, or oral sex with another person is putting him/herself at risk for HIV and other STDs.*

Myth: If a person has unprotected sexual contact, he/she can get tested for HIV and get the results by the next day.

Fact: When a person is infected with HIV, the immune system produces antibodies to fight the HIV. As a result, HIV tests look for HIV antibodies. These antibodies are not, however, developed immediately. Most people will develop these antibodies between 25 days and six months after they become infected. The time period between a person becoming infected and developing antibodies is known as the window period. If a person tests negative for HIV during the window period, they can't be sure they don't have HIV, because the antibodies may not have been produced yet. It's best, therefore, to get tested at three months, then again at six months, and then again at a year, and to use latex barriers for all sexual behaviors.

Myth: During the window period, an infected person cannot transmit HIV to others.

Fact: Just because an infected person hasn't yet developed antibodies to HIV, she or he is still infected and can transmit HIV to another person. This means that if you get a negative test results in the first three months, it doesn't necessarily mean that you don't have HIV – or that you can't give it to someone else.

Myth: People under 18 need their parents' permission to get tested for HIV or other STDs.

Fact: No parental permission is needed for anyone to get tested for HIV, STDs, or even pregnancy.

Overview of HIV Testing

From "The Body" -- http://www.thebody.com/sfaf/hiv_testing.html#urine

What Are HIV Antibody Tests?

As the body fights viruses, it creates antibodies to that virus. HIV antibody tests measure the presence of antibodies to HIV. They do not measure or detect the virus itself. There are three commonly used antibody tests.

Why Should You Be Tested: Some of the Pros and Cons

Pros

- If you know you are HIV-positive, you can take advantage of immune system monitoring and early treatment and intervention.
- By taking the test, you can find out whether or not you can infect others.
- Regardless of the result, testing often increases your commitment to overall good health habits.
- If you test negative, you may feel less anxious after testing.
- Women and their partners considering pregnancy can take advantage of treatments that potentially prevent transmission of HIV to the fetus or baby.

Cons

- If you test positive, you may show an increase in anxiety and depression.
- When testing is not strictly anonymous, you risk job and insurance discrimination. You can prevent this by ensuring that you test at an anonymous testing site.

Whether or not to take the antibody test is an extremely personal decision. The decision is for each person to make for her or himself.

Window Period

The "window period" is the time it takes for a person who has been infected with HIV to *seroconvert* (test positive) for HIV antibodies.

The Centers for Disease Control (CDC) says about the window period:

"Antibodies generally appear within three months after infection with HIV, but may take up to six months in some persons."

This CDC definition of a three to six month window period has been commonly used for a number of years and is most often used.

What Does This Mean for You?

- The three month window period is normal for approximately 95% of the population. Many people will have detectable antibodies in three or four weeks. *Very, very* rarely (i.e., only a few cases *ever*), a person could take a year to produce antibodies.
- You may be anxious to be tested soon after an encounter which you perceive to be risky (and in many cases, the encounter actually *isn't* risky). You want to know: can I be antibody tested without waiting three months? How accurate is the test after, say, six weeks? Unfortunately, we don't know. Think about this: if you got a negative test at six weeks, would you believe it? Would it make you less anxious? If so, go for it. But to be certain, you will need to be tested again at six months.
- You may have "heard" that AIDS/HIV can take years to be detectable. Here's the clarification: *AIDS*, or the clinical symptoms that define it, takes many years to develop after exposure. *HIV* -- the virus that causes AIDS -- is usually detectable within three months after exposure, and does not cause symptoms in most people.

Interpretation of Test Results

A **positive** result means:

- You are HIV-positive (carrying the virus that causes AIDS).
- You can infect others and should try to take precautions to prevent doing so.

A **positive** result does **NOT** mean:

- You have AIDS.
- You will necessarily get AIDS.
- You are immune to AIDS, even though you have antibodies.

A **negative** result means:

- No HIV antibodies were found in your blood at this time.

A **negative** result does **NOT** mean:

- You are not infected with HIV (you may still be in the "window period").
- You are immune to AIDS.
- You have a "resistance" to infection.
- You will never get AIDS. You may wish to consider avoiding unsafe activities to protect yourself.

An **indeterminate** result (which is rare) means:

- The result is unclear. The entire HIV test must be repeated with a new blood sample, usually several weeks after the first blood test.
- Indeterminate results usually occur if the test is performed just as the person begins to seroconvert.

Types of Tests:

Home HIV Antibody Test

What: At this time one company, Home Access, offers an FDA-approved in-home antibody test. This test costs about \$45 to \$70, depending on whether you pay for 72-hour results (they give you a pre-paid express delivery envelope to expedite shipping your sample to the lab) or standard 7-10 day results.

How: Home Access uses a blood sample from a finger prick, which is sent to a certified laboratory for testing. You must call a toll-free number to register your sample prior to shipping. Enclosed in the test kit is an identifying number. Results take three days to one week. To obtain results, you give the operator the ID number, they will look up the result of the test.

Accuracy: They use traditional testing procedures, so the results are as accurate as one would receive at anonymous testing sites discussed above.

Note: There is no automatic prevention education or pre-test counseling with this method of testing (although you can specifically request it with Home Access). Testing companies may also offer post-test counseling for some results, but not others. Also, we have a concern that consumers may not always be able to take the test in privacy if they live with others.

However, the speed of the test may offer an advantage, although more and more anonymous testing sites are offering one week (or less) results, at no cost. The privacy of the home test offers some consumers more comfort than going to a public test site. Remember, as with testing at an anonymous or confidential site, you must wait three to six months after HIV exposure to take the at-home test.

Urine Test for HIV

What: A test that detects HIV antibodies in urine was approved by the FDA in 1996, and is beginning to be marketed. ***This test is not generally available to consumers.*** It is marketed to insurance companies, medical providers, and to other countries. It is more expensive than a blood test. (Note: urine has *antibodies* for HIV, *not HIV itself*, so HIV is *not transmitted* by urine.) It is called the "Sentinel" test.

How: A sample of urine is tested at a certified lab, using a modified ELISA procedure. This test must be ordered by a physician; a person cannot "self-refer" like they can with traditional HIV antibody tests. This means the *urine HIV test*, by definition, is *confidential*, not anonymous.

Accuracy: Because it is *less sensitive than a blood test*, positive results must be confirmed by a traditional blood test.

Orasure Test for HIV

What: The OraSure HIV antibody test method uses a sample of oral mucus obtained with a specially treated cotton pad that is placed between the cheek and lower gum for two minutes. *(Note: the saliva and oral mucus contain antibodies to HIV, not HIV itself, so HIV is not transmitted through these fluids.)* Some public test sites are beginning to offer this test as an alternative to blood testing. It is somewhat more expensive, so the client may be asked to pay for it.

How: The sample is sent to a lab, so this is not a "rapid test" for HIV. It will take from a few days to a few weeks to get results, depending on the test site's choice of lab.

Accuracy: The combined accuracy of OraSure and the lab procedures is comparable to traditional blood testing (very high).

**For more information/current information
about STDs and HIV on the
World Wide Web:**

Advocates for Youth – www.advocatesforyouth.org

American Social Health Association – www.iwannaknow.org

The Body – www.thebody.com

Gay Health -- www.gayhealth.com

Gay Teens – www.gayteens.org (click on “sexual health”)

SEX, ETC. – www.sexetc.org

Planned Parenthood – www.plannedparenthood.org/stis

SESSION THREE

“MAKING SAFER SEX FUN”

RATIONALE:

Perhaps the greatest challenge to addressing safer sex with individuals of any age is the concern that safer sex detracts from sexual pleasure, intimacy, and spontaneity. Simplistic, ineffective responses to this very real concern have included that admonition that a person should not choose sexual pleasure over sexual health. While this may be the case, it is not an effective message for teenagers – or people of any age. We must, therefore, help them identify alternatives to high risk sexual behaviors and find ways of making these behaviors fun, intimate, and enjoyable so that they will be as appealing to engage in as a higher risk activity.

TIME:

2 hours

GOALS:

To help participants to:

- Understand what “safer sex” entails, and the reasons why LGBTQ teens might or might not choose to practice safer sex.
- Learn about safer sex methods, and practice how they can use these methods in fun, sexy ways.

OBJECTIVES:

By the end of this session, participants will be able to:

- Define “safer sex”.
- Name at least three types of intimate behaviors people can engage in that do not carry risk for STD or HIV infection.
- Identify, for at least three sexual behaviors, whether each carries high, low, or no risk for STDs and/or HIV.

- Explain how latex and polyurethane barriers protect against high-risk sexual behaviors, and the steps for using at least two of these types of barriers.
- Describe at least one way in which a safer sex method could be used that would make it fun and/or sexy

MATERIALS:

- Blank newsprint pad and easel
- Newsprint markers
- Masking tape
- Large, 5 x 8” index cards in different colors, or 8 ½ x 11” sheets of different colored card stock paper
- One small paper (lunch) bag
- One larger brown bag
- Scissors
- Smaller index cards, enough so each participant has several
- Facilitator’s resource, “Intimate Behaviors”
- Facilitator’s resource, “Safer Sex Methods”
- Extra pens or pencils

Safer sex supplies:

- Unflavored male condoms
- Flavored male condoms
- Dental dams
- A roll of Saran or other store-bought plastic wrap
- Several types of lubricants, flavored and unflavored
- Latex gloves
- Finger cots
- Penis models or bananas, enough for half the group
- Large apples, cut in half, enough for half the participants each to receive half an apple

ADVANCE PREPARATION:

1. Tear at least twenty one-inch pieces of masking tape, and attach them to the edge of a desk, chalkboard, or easel where they can be easily removed.
2. Draw three large signs made from half-sheets of newsprint paper, one of which reads “Higher risk,” one of which reads, “Lower risk,” and one of which reads “No Risk”

3. On four small sheets of paper, write: “two women”, “two men,” “two women and a man,” and “three men.” Place these inside the small, brown lunch bag.

4. Inside the larger brown bag, put:
 - two dental dams
 - several flavored male condoms
 - two latex gloves
 - a finger cot
 - several small tubes of lubricant
 - two unlubricated male condoms

PROCEDURE:

Re-entry (10 minutes)

1. Remind participants of the last session’s topic. Ask whether there are any questions left over from that session. If so, and they are more than a quick question-answer, have the participants write them down on index cards for you to take away, write the answers to, and return with at the next session.

2. Explain that today’s session is designed to look at different sexual behaviors and how risky they are for STDs and HIV. Ask: *“What is ‘safer sex’?”* Probe for answers that, together, embody the following:

“engaging in sexual behaviors that significantly reduce the risk for a sexually transmitted disease – or, if there’s both a penis and a vagina involved, a pregnancy.”

Ask, *“When you think of practicing safer sex, what words come to mind?”* Possible responses may include:

- Difficult
- Easy

- Not going to happen
- Don't need it
- Boring
- Kills the moment
- Important

Say,

“There are often positive and negative words or connections that come with the idea of safer sex. The purpose of today’s session is to go over some information about safer sex, while coming up with ways of making safer sex fun, sexy, and effective.”

Behavioral Risk Continuum/Methods of Safer Sex (40 minutes)

Setting up the activity (10 minutes)

1. Say,

“Many of you have probably heard the expression that the safest sex is no sex. But when people do have sex, they can do one of two things: they can do something sexual that doesn’t carry any risk for STDs or HIV, or they can use latex barriers, like condoms and dental dams, to avoid sharing bodily fluids like semen, vaginal fluids, and blood. We’ll talk about these behaviors in more detail later in this session. But right now, we’re going to look at ALL types of sexual behaviors, regardless of their risk for STDs, including HIV.”

2. Break the large group into smaller groups of four or five participants. Distribute ten large index cards to each group and a dark-color newsprint marker. Ask the groups to come up with as many intimate behaviors they can think of that people can do to share sexual intimacy and pleasure. Be sure to encourage them not to censor themselves. Ask them to write only one behavior on each index card, as big and clearly as they can. Let them know that you have more index cards if they need more than ten.

Note to the facilitator: *A list of possible responses is included in the facilitator’s resource, “Intimate Behaviors”. You may wish to have index cards prepared in advance of the session for the behaviors you want to be sure to discuss in order to supplement what the small groups may come up with. You can simply put them aside if the groups think of these behaviors on their own.*

3. While groups are working, post the “higher risk,” “lower risk” and “no risk” signs at the front of the room at the top of the wall or chalkboard, allowing sufficient space between the three.

How Risky Is This? (20 minutes)

1. After about 10 minutes, ask the groups to go through their cards and decide whether each behavior carries high risk, medium or lower risk, or no risk for STD or HIV transmission. Then ask someone from one of the groups to bring two of their index cards to the front of the room and tape the cards where they think they belong. While s/he is doing this, ask the other groups to put aside any cards they may have written that duplicate what is being placed up on the front wall. Go around to each group and have a volunteer post two of the group’s cards on the safer sex continuum.

2. Once all the groups have placed two cards up on the front wall, do another round with the groups, where each group comes up and tapes two more of their cards where they think they go on the continuum. Again, have any other groups watch and take out duplicate cards from their piles. Go from group to group in this way until all the non-duplicated cards are taped up to the front of the wall.

3. Once all the non-duplicated cards have been taped to the front wall, ask the participants to review them. Starting with the highest risk category, go through each behavior, making sure that everyone understands what it is, and why it is in this category.

Note to the facilitator: *The attached facilitator resource can help you with this. If, however, the participants contribute behaviors with which you are not familiar (and they will!), be sure to ask them what they mean. Sometimes, people have different names for the same behaviors. In addition, participants may not differentiate between behaviors during which latex is and is not*

used. If that were to be the case, ask, “What would you add or take away from this behavior to make it move to another category?” Answers might include “some kind of latex,” “lube” or “lubricants,” or something else.

In each case, ask whether people agree with its placement, or whether they would suggest that the behavior be moved to another category, and why. If the group cannot agree as to whether the card should be moved, place the card in its appropriate place and explain why it belongs there.

4. Process by asking the following:

- *“What was it like to do that? What was [insert participants’ responses] about it?”*
- *“What themes did you notice within the risk categories?”*
- *“Since so much risk is associated with exchanging fluids, why do you think some people do not use latex barriers?”*

5. After hearing responses to the last question, explain that you are going to move into talking about what people can do to make using latex barriers or otherwise practicing safer sex fun.

Making Safer Sex Fun (60 minutes)

Method Demonstrations (35 minutes)

Go through the safer sex methods you brought with you. Be sure to talk about the different ways in which each method can be used, and the various behaviors involved. Use the facilitator’s resource, “Safer Sex Methods” as a guide as needed.

During the male condom demonstration, the topic of nonoxynol-9 will likely come up. Address it in the following way:

“Many condoms are still made with Nonoxynol-9 in the lubricant. Nonoxynol-9 is a spermicide, meaning it is designed to kill sperm. HIV and other STDs, however, can be found in semen, the

fluid in which sperm is found. Nonoxynol-9 does not do anything to kill HIV or to prevent any other STDs. In addition, recent research has found that lubricants with Nonoxynol-9 can, under some circumstances, actually increase a person's risk for getting HIV. So it's best to use condoms that are lubricated with something other than Nonoxynol-9, or to get non-lubricated condoms and apply a water-based lube like K-Y Jelly, Slippery Stuff, or something else."

Note to the facilitator: *Be sure to practice demonstrating these methods BEFORE the session, regardless of how long you may have been working in the field, or of your own personal experience in using the methods. Demonstrating them in front of a group can be much more stressful, so you want to be sure you feel ready before going in.*

Making Safer Sex Fun (25 minutes)

1. Let the group know that you are now going to have them show how they can take the demonstration you just did and make it fun and sexy!
2. Break the group into four smaller groups. Walk around the room with the larger paper bag, and have one member of each group reach in and take out two different methods from the bag (for example, they should not take out two condoms or two latex gloves).
3. Once every group has selected their methods, go around again with the small paper bag that contains the small pieces of paper with different types of relationships listed on them. Ask a member of each group to select one piece of paper from that bag.
4. After every group has selected, tell them that they have about 10 minutes in which to write a scenario in which the people on the sheet they selected are using the two methods they selected in fun, sexy ways. Let them know that they should write something that they would want everyone to see, since the groups will be presenting their scenarios to the larger group. Provide each group with a blank sheet of newsprint and a marker.
5. After 10 minutes, have the groups come to the front of the room in turn and present their ideas. Ask for feedback from the group, including any additional ideas for each presentation.

Note to the facilitator: *You may wish to make this into a competition, having the groups vote on the hottest, safest scenario and awarding a small prize to that group.*

6. Process by asking the following questions:

- *What was it like to do that? What was [add in participants' responses] about it?*
- *What, if any, similarities did you notice in the presentations?*
- *What is something you can take away from this activity that you'll be able to use in your own life?*

Closure: “Safer sex can be fun if...” (10 minutes)

1. Distribute small index cards (and pens or pencils to those who may need them), and ask participants to write, anonymously, the end to the sentence stem, “Safer sex can be fun if...”
2. Once everyone has finished, collect the cards, mix them up, and redistribute them to the group.
3. Go around the room and have each person read what is on his/her card. Ask them not to say whether they got their own, or if they recognize someone else's handwriting.
4. Summarize the session by saying,

“Safer sex takes work. But it can also be a lot of fun. Is it the same as engaging in unprotected sexual behaviors? No. But it can be extremely enjoyable. It can also enhance the feelings of sexual pleasure because the concern about getting infected with an STD or HIV will be decreased. Keep in mind that having unsafe sex, even once, does put people at risk for STDs, including HIV, as well as pregnancy if people are having penis-vagina sex. Safer sex is about creativity and imagination; about self-worth and self-respect; and about responsibility and ethics. We're going to talk about this more in the next session. Safer sex takes planning and a

sense of commitment from everyone involved. But as you also just experienced, there are many ways to make safer sex fun, enjoyable, sexy, and something you can feel good about choosing, regardless of the type of relationship you are in.”

5. Thank participants for their work, and close the session. Remind them of the time and place for Session 4.

Handouts/ Facilitator Resources

SESSION THREE

Intimate Behaviors

***Note to the facilitator:** This list is for suggestion purposes only. Please adapt this list, adding to or deleting from it, according to your individual audience's level and needs.*

- | | |
|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Penis-vagina sex without a condom | Watching people have sex together |
| Vaginal sex, using a dildo, without a condom | Hugging |
| Vaginal sex, using a dildo, with a condom | Bondage play – no penis-vagina, penis-anus, or oral sex |
| Penis-anus sex, without a condom | Phone sex |
| Tongue (“French”) kissing | Fisting (inserting all five fingers or the entire fist into a vagina or anus), no latex or glove |
| Closed-mouth kissing | Fisting, with latex |
| Body rubbing | Cybersex (sex talk via the computer, often with masturbation involved) |
| Mutual masturbation (touching each others’ genitals, no finger cots or latex gloves) | Rimming (oral sex on an anus) using a dental dam, cut-open condom, or plastic wrap |
| Solo masturbation (touching one’s own genitals for pleasure) | Rimming, no latex barrier |
| Group sex (any types of behaviors), no latex | Naked massage |
| Group sex (any types of behaviors), some latex | Showering or bathing together |
| Group sex (any types of behaviors), all latex | Fingering/finger popping (digital pleasure to a vulva or anus), no finger cot or latex glove |
| Tea bagging (oral sex on a scrotum) | Fingering/finger popping, with latex |
| Harmonica job (oral sex on shaft of the penis, avoiding the head) | Penis-vagina sex with a condom |
| Oral sex on an entire penis using a condom | Oral sex on a penis without a condom |
| Oral sex on a vulva with a cut-open condom/dental dam or plastic wrap | Oral sex on a vulva without a cut-open condom, dental dam or plastic wrap |
| Dry humping (rubbing genitals together, some clothing on) | Anal sex using a dildo |
| Watching someone masturbate | Any sexual behavior while drunk or high |

Safer Sex Demonstrations

Latex condoms

For use on a penis or dildo

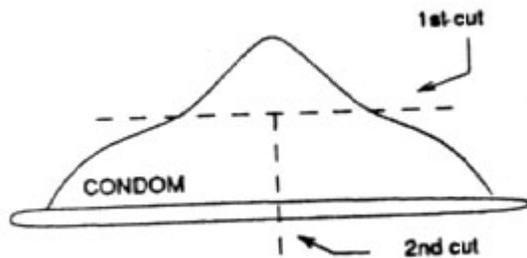
Using the penis model or banana, walk through the steps of putting a condom on a penis, using the following guide as necessary. Be sure to note that some steps, such as talking about condoms or loss of erection, can happen at different times during the process. Also be sure to explain that these steps can be used for a penis or dildo, but that the steps you'll be discussing are specifically about a penis, since there may be more issues to take into consideration (e.g., what to do with the foreskin on an uncircumcised penis).

- Talk to partner about using condoms.
- Buy/pick up condoms.
- Check the expiration date.
- Hold condom up to the light to check for holes.
- Push condom slightly out of the way and tear condom open. Never use teeth, and watch sharp nails!
- Check to see that condom is right side up. If condom is put on penis upside down, throw away and get a fresh condom (pre-cum).
- Get erection
- If penis is uncircumcised, pull back foreskin to expose head.
- Add a small amount of WATER-BASED lubricant inside the condom or on the head of the penis to increase sensitivity (optional)
- Place condom on tip of penis.
- Pinch tip of condom to remove air.
- Unroll condom all the way down to the base of the penis, gently smoothing out air bubbles.
- Add water-based lubricant (optional, or if not lubricated already)
- Sexual contact
- Pull penis out of partner's body while holding the base of the condom to keep condom from slipping off
- Loss of erection.
- Remove condom carefully to keep contents from spilling.
- Tie a knot in condom, and throw away in garbage. Never re-use a condom, and never flush one down the toilet.

For oral sex on a vulva or anus

- Follow steps 1 – 5 above, using a flavored condom.

- Take scissors and insert one blade inside the condom. Cut condom in half, and unroll it with the flavored side facing you. Or, follow the diagram below:



- Place unrolled flavored condom over cut-open apple to simulate a vulva or anus, emphasizing the importance of covering as much area as possible.

Variations/additional uses:

- Demonstrate how to do the same using a fingernail to tear the opening of the condom and remove the ring around the opening of the condom, in case scissors are not available.
- Keep ring to demonstrate how it can be used to tie back a person's hair before performing oral sex.

Polyurethane pouches

The pouch and vaginal sex:

Note to the Facilitator: female reproductive models can be challenging to find, and expensive to purchase. If you are unable to find one, simply use one hand to simulate a vaginal opening, and the other to insert the "female condom" or pouch.

- Check the expiration date.
- Open the package carefully.
- Take the internal ring – the one that does not have an opening – and put it between the thumb and forefinger on one hand.
- Insert pouch into "vagina", leaving the ring on the open end outside the vaginal opening.
- Penis goes inside the pouch.
- After ejaculation, remove penis from vagina. Twist the outer ring several times to keep contents inside pouch.
- Pull condom out and discard. Do not reuse.

The pouch and anal sex:

- The pouch was not made for anal sex, and its packaging does not encourage using it for anal sex.
- Some men do choose to use it for anal sex anyway, and think it works fine for them.

- Studies have shown that almost half report at least “some problem” with using the vaginal pouch for anal sex, including discomfort, rectal bleeding, and difficulty keeping it in place.
- If used for anal sex, the same instructions as listed above should be followed. Some people, however, choose to remove the inner ring, or to place the pouch around the penis before it goes inside another person’s body. Additional lube comes with the pouch, and insertion and removal should be done slowly. It is important for people to remember that the rectum and the vagina are quite different in that the rectum can “pull” things inside it, making them much more challenging to remove. For this reason, some men will choose to put the pouch on their penis before putting their penis inside their partner’s body.
- Never reuse a pouch for anal sex.

Dental dams

- Dental dams come in different sizes; they are not always easy to find outside of adult stores and web sites, which are usually not accessible to teens. They are available at some health clinics.
- Open package, and place scented or flavored side facing up.
- Add a small amount of WATER-BASED lubricant on the side facing the vulva or rectum for greater sensitivity (optional)
- Perform oral sex on vulva or anus through the dental dam. Either partner can hold dam in place.
- When done, discard – do not reuse.
- Can use Saran wrap as a dental dam, too, following directions above.

Finger cots

- Are easily found in drugstores; usually used to cover fingers that have cuts on them to enable people to continue working.
- Should only be used once, and a finger that is covered by a cot should not go from one body opening to another (e.g. not from vagina to anus or anus to mouth, etc.).
- A new cot should be used for every new act.

Latex gloves

- Are easily found in drugstores; different colors are found through adult themed stores and websites, which are usually not accessible by teens.
- Should only be used once; as with finger cots, a finger or hand that is covered by a latex glove should not go from one body opening to another (e.g. not from vagina to anus or anus to mouth, etc.). A new glove should be used for every new act.
- If using several fingers or an entire hand or fist for penetration, a LOT of water-based lube should be used. Same rules about non-water-based lube that apply to latex condoms apply to gloves and cots, too.

Condom diagram from the Williams College web site, accessible at <http://wso.williams.edu/orgs/peerh/sex/safesex/condom.html>

SESSION FOUR “PRACTICING SAFER SEX”

RATIONALE:

There are different factors that influence how or whether people practice safer sex: first, the risks for sexually transmitted diseases (and pregnancy when a penis and a vagina are involved); and second, the people or factors that can encourage or deter a person from practicing safer sex. Talking about anything related to sexuality is a challenge, so discussing safer sex can be even more daunting. It is vital, therefore, for young people to examine how they feel about sexual behaviors, and understand what can affect whether and how they can discuss safer sex with partners, both new and ongoing. They also need to develop the skills for recognizing barriers to practicing safer sex and for overcoming those barriers in order to remain sexually healthy.

TIME:

2 hours

GOALS:

To help participants to:

- Reflect on their values and beliefs about practicing safer sex, and be able to translate those values and beliefs into their daily lives and relationships.
- Understand how the type of sexual relationship they have can affect their decisions about practicing safer sex.
- Recognize the potential obstacles to practicing safer sex, and learn ways of strategizing how they can overcome those obstacles.

OBJECTIVES:

By the end of this session, participants will be able to:

- Name at least one value or belief they hold pertaining to safer sex and responsibility.
- Identify at least two potential obstacles to practicing safer sex, and at least two strategies for overcoming these obstacles.

MATERIALS:

- Blank newsprint and easel
- Markers
- Masking Tape
- Handout: “How Do You Know Who To Trust?” enough copies so that each participant has one
- Handout: “Relationship Criteria,” enough copies so that each participant has one
- Extra pens or pencils
- Blank paper

ADVANCE PREPARATION:

On a sheet of newsprint, draw a rating graph with enough rows and columns for the number of characters in the story “How Do You Know Who To Trust?” and number of smaller groups.

Example:

	Group One	Group Two	Group Three
Brian			
Ken			
Samantha			
LaShawn			
Clinician			

PROCEDURE:

Re-entry (10 minutes)

Remind participants of the last session’s topic. Ask whether there are any questions left over from that session. If so, and they are more than a quick question-answer, write them up on the parking lot in order to have time to discuss them later.

“How Do You Know Who To Trust?” (45 minutes)

Introduction and Activity Setup (10 minutes)

1. Let participants know that in today’s session you will be talking about safer sex. Ask, “Why do we talk about ‘safer’ instead of ‘safe’ sex?” Probe for the idea that any sexual behavior will carry some kind of risk, so there is no truly ‘safe’ sex.

2. Say,

“Safer sex is about more than information, which we will be discussing later in the session. It’s also about how to recognize when someone’s doing something that’s putting themselves and others at risk. We are going to do an activity now that does just that.”

3. Distribute the worksheet, “How Do You Know Who To Trust?” Read through the entire story aloud. After you have finished reading the story to the group, ask everyone to rank order the characters at the bottom of the sheet by how responsibly and ethically each one acted in the story. The person who acted MOST responsibly and ethically should receive a “1” and the person who acted LEAST responsibly and ethically should receive a “5”. All other characters should be ranked from 2 – 4.

Note to the facilitator: *If participants ask for definitions of what “responsible” or “ethical mean,” ask for definitions from the group. Emphasize, however, that it’s important for them to think for themselves about what it means to be ethical or responsible.*

Emphasize the following rules:

- Everyone should fill out their own sheet without discussing it with another person.
- No character can receive the same number as another character – they cannot, for example, be all 5s or three 2s and two 4s.

Worksheet discussion and consensus-building (20 minutes)

4. After 5 minutes, or after everyone has completed the sheet, divide the group into smaller groups of three to four. Provide them with the following instructions:

- Find out how each person in the group rated the characters in the story.
- Discuss the story and the ratings in order to reach consensus – meaning, everyone has to agree on the ranking for each character.

Remind the group about the ground rules or group norms they established, so that when they disagree they should do their best to do so respectfully.

5. Move around the room and observe the small groups, intervening only if you feel participants are being disrespectful to one another, and redirect the discussion by reminding them of the ground rules or group norms.

As groups are working, either draw on the board or post the newsprint sheet of paper with the graph of characters and the potential rankings for use in the report-back and processing section that follows.

Report-back and process (15 minutes)

6. Ask participants to stay in small groups, but ask them to close their discussions. Ask, “How many groups reached agreement on all the rankings?” You can also ask how many reached consensus on four, three, two, one, or none of the characters. Avoid processing it at this point, since you will be returning to it later. The purpose of asking is simply to give people a sense of where the group is at the end of the process.

7. Go around the room, and have each group share the rating they gave each character. Record them on the sheet or chart at the front of the room. Once the chart is completed, ask participants for their reactions. These responses will depend on what is on the board, but can range from noticing that all or almost all of the groups ranked the characters the same; that every group was different; that there were similarities with some characters but not with others.

8. Process the activity using the following questions:

- What was it like to do that? What was [fill in participant's response] about it?
- What was it like to try to reach consensus? What was easy or challenging about it?
- What were some of the things that led you to rank people as a 5? As a 1?
- How do you define “responsibility” and “ethics”?
- If you were in [name character]'s position, how easy or difficult do you think it would have been to stop and talk about safer sex? Do you honestly think you'd have been able to do something different? Why or why not?
- In these situations, the characters knew each other. What's similar or different in a situation where someone's just met a person and they end up having sex with him or her?

9. Close the discussion by saying:

“A big part of looking at our values and beliefs – particularly around things like ethics and responsibility – is that there's not necessarily one right answer. Also, what we may think is the most ethical or responsible choice may not be the same as what our partner thinks. And regardless of what we may know in our heads, it may be really difficult to remember that when we're in a moment that has sex and/or love involved. We're going to talk about that more in this next section.”

10. Ask participants to thank their small group co-members for working together, and have them return to their original seats.

Overcoming obstacles to practicing safer sex (60 minutes)

Brainstorm and Discussion of Relationship Characteristics (30 minutes)

1. Break the group into pairs. Give each pair a pen or pencil and a piece of paper and ask them to brainstorm all the possible types of relationships people can have (focusing on romantic and/or sexual relationships). Ask the first pair that comes up with five to raise their hands, and ask everyone to stop at that point.

2. Have that group record their list on the board. Responses may include:

- One-night stand
- Friends with benefits
- Sex for money
- Exclusive, ongoing
- Open relationship (can see other people)
- Affair/cheating (main relationship, one or both people going outside the relationship and not telling each other)
- Polyamorous (more than two people in the relationship; shared love and/or sex partners)
- Cyber/online
- Long distance
- Romantic, non-sexual

3. Ask other pairs to supplement with anything on their lists that might not appear here.

4. Count the group off by fives (or as many types of relationships as you have listed at the front of the room), making sure each group has at least two people in it. Assign each group one of the types of relationships listed at the front of the room, making sure that “exclusive, ongoing” or “monogamous” relationship is among them.

5. Distribute the worksheet, “Relationship criteria.” In their small groups, have the participants write down the type of relationship they were assigned, and then discuss, together, what they would look for if they were interested in that type of relationship. Have them complete the rest of the form together, discussing ideas, and trying to agree as much as possible on their options.

6. After about 15 minutes, provide each group with a sheet of newsprint and a marker, and ask them to write their responses on the sheet. After about five minutes, ask them to stop and turn their attention back to the large group.

7. Ask for one group to volunteer to talk about their type of relationship and what they came up with. Focus in particular on the issues that may get in the way of a couple being able to practice safer sex. Possible responses might include:

- If they don't love each other, then they might not care so much about whether they give someone an STD.
- If one person is in love but the other isn't, they may be willing to take risks to be with that person.
- If the person's really cute, you may not be thinking about using latex.
- If it's someone you know really well, you might not think they could end up with an STD.
- If the person's really cute and looks good, you might not think that her or she could have an STD.

As the group reports on their answers, guide them with the following questions:

- What kinds of obstacles did you identify to practicing safer sex? What role did the type of relationship you were seeking play in creating these obstacles?
- What kinds of strategies for overcoming these obstacles did you identify? How realistic do you think they are?
- What kinds of consequences did you think there would be as a result of trying to practice safer sex?

8. Ask for a volunteer from another group to talk about the relationship they discussed and what issues came up. Guide their discussion with the same questions. Depending on time, allow each group to report.

Note to the facilitator: *As each group takes a turn, the reporting time should continue to decrease for each group since many of the issues will be the same. Groups can acknowledge issues that they discussed that were similar to others already reported but should not spend a lot of time discussing previously covered ground.*

9. After you have read through all of the lists, process using the following questions:

- What was it like to do that activity? What was (participant's response) about it?

- What do you notice about the lists? (Probe for similarities, unique aspects, etc.)
- In which type of relationship do you think it would be easiest for someone to make sure to practice safer sex? Why?
- In which type of relationship do you think it would be most difficult for someone to make sure to practice safer sex? Why?
- What does doing all this tell you about what we need to do, regardless of the type of relationship we're in, if we want to be sure to practice safer sex?

Closure: “One thing I plan to think more about...” (5 minutes)

1. If the group is small, go around the circle and ask each person to finish the statement, “As a result of today’s session, one thing I plan to think more about is...” If the group is too large to allow time for each person to speak, ask for volunteers and have a few people share their responses.

2. Summarize the session by saying, “We tend to hear a lot about safer sex – what it is, what kinds of behaviors are lower risk, and more. But we don’t always think about what it takes to actually practice safer sex. There’s a lot of thought, planning, and other factors we have to take into consideration, regardless of whether this is someone we’re with for a long time, or plan to be, or someone we just met and want to be with for a night or the short-term. Practicing safer sex is so important – but it takes work, especially if the people involved aren’t on the same page about it.”

3. Thank participants for their work, and close the session. Remind participants of the time and place for Session 5.

Handouts/ Facilitator Resources

SESSION FOUR

STD Issues in Different Relationships

Note to the facilitator: Be sure to review the following as a guide before the session and to keep it handy when discussing different types of relationships and the partners' risks for STDs. Keep in mind, however, that the group may come up with relationship types that do not appear here.

In a secret affair/cheating relationship

- There may be a lack of trust and open communication, which can impede a couple's ability to negotiate safer sex honestly.
- If there is one lie there may be more (e.g., "I have never been with anyone else," "I just got tested and am clean," etc.)
- One partner may believe that his/her partner is being monogamous and therefore that there is no need to practice safer sex with him/her.
- Cheating shows a lack of respect for one's partner that may carry over into lack of concern about keeping that partner safe.
- If the cheating partner gets an STD from the person with whom they are cheating, he/she may not tell their primary partner about it because it would mean revealing that they were cheating.

In a "friends with benefits" relationship:

- Since there is often no expectation of monogamy, the people involved may feel comfortable having sexual relationships with other people, too. This multiple partnering makes it much more difficult to know if a partner is being safe, and it puts all parties involved at greater risk.
- Truly good friends, especially long-time friends, may be more able to treat the sexual arrangement in a way that both parties are satisfied, and therefore they may be able to negotiate safer sex more directly and clearly.

In an exclusive, ongoing (monogamous) relationship

- Truly committed relationships have the potential for more open, honest communication about sexual histories, testing, infection, and safer sex.
- Partners may be reluctant to bring up safer sex or condom use for fear that their partner might think they are cheating on him/her.
- Partners might falsely assume that if their partner is monogamous they are not at risk, ignoring previous sexual histories that might put both partners at risk.

In Sex for Money

- A person may put him/herself at high risk for STDs if the other person is willing to pay more for unprotected sex.
- There can be an inherent power differential, which can result in one person making the decision about safer sex practices rather than everyone involved.
- If it's a clearly negotiated relationship, there may be space to negotiate safer sex more clearly as well.

In a One-Night Stand

- There may be little incentive for a person to warn their sexual partner that she/he is infected if she/he doesn't plan on ever seeing them again.
- Frequent one-night stands can put a person at higher risk for STDs, since the risk increases as the number of partners increase.
- Someone who has many of these types of relationships may automatically practice safer sex routinely.
- Because it is hard enough communicating about safer sex with a partner in a more committed relationship, discussing safer sex with a stranger (or virtual stranger) may be much more unlikely.
- Because the relationship is only going to last for one night, discussing and practicing safer sex with that stranger (or virtual stranger) may be much easier and therefore more likely.

- One or all of the people involved may feel that one-night stands are for having fun, not for talking about disease.
- If the people involved were not planning on it ahead of time, they are less likely to come prepared for safer sex.

In an open relationship

- Partners are aware of outside relationships and might be in a better position to negotiate safer sex.
- If the number of partners is large, it can substantially increase the risk for STD infection for everyone involved.

In a polyamorous relationship

- Partners are aware of other relationships and might be in a better position to negotiate safer sex.
- If the number of partners is large, it can substantially increase the risk for STD infection for everyone involved.
- Commitment and expectations within the relationship are usually discussed openly, which can increase the likelihood of all partners practicing safer sex.

In a cyber/online relationship

- There are no risks for STDs if the people do not meet in person. If the people decide to meet in person, it may be easier to have a discussion about safer sex online ahead of time, rather than in person, which may make that conversation more likely to occur.
- The on-line relationship may be seen as threatening to a partner in an in-person relationship with one of the people in the online relationship, which might cause problems in that in-person relationship; if this includes acting out sexually (e.g., having sex with another person to get back at the partner who is having a cyber relationship), it can increase STD risk.

In a long-distance relationship

- There are lower risks for STDs if the partners have agreed to be monogamous.

- There can be higher risks for STDs if partners have different expectations around monogamy and have not talked about them. If the partners both agree to be monogamous, but one or both is unable to sustain that promise over time, it may be difficult to talk about that truthfully, which can interfere with the ability to negotiate safer sex appropriately.

In a romantic, non-sexual relationship

- There are no risks for STDs if there is no sexual contact between partners.
- If partners do not at least talk about STD risk and risk reduction methods, they may not protect themselves as effectively if they do choose to become sexually active.

Take-home points:

- ✓ Regardless of the type of relationship, the degree to which partners practice safer sex is the main factor in STD risk.
- ✓ There are, unfortunately, many reasons why someone might lie about her/his sexual history (they don't want to scare away a potential partner, they are embarrassed by their history, they don't believe it is important, etc.).
- ✓ Even if someone is able and willing to share his/her sexual history, he/she may not know it completely. (He/she would know who he/she may have been sexual with but probably would not know all of the people that previous sexual partners had been with and who could have put him/her at risk). He/she may have an STD and not know it. The most common STD symptom is no symptom.

“How Do You Know Who To Trust?”

Brian and Ken have known each other since they were kids. They're both 15, and go to the same high school. Brian is gay, but hasn't come out to anyone yet. Ken's on the football team and has a girlfriend, Samantha. The three of them hang out together a lot, and Samantha is always trying to set Brian up with her girlfriends.

One night, Brian and Ken are hanging out at Ken's house. His parents aren't home, and he asks Brian if he wants a beer. They drink a few beers together and watch a DVD, each of them getting buzzed. Out of nowhere, Ken leans over and kisses Brian. Brian backs away and tries to ask, “What...?” but Ken tells him to shut up, and kisses him again. They keep fooling around and have oral sex. Brian thinks about stopping to get a condom – he has one in his backpack from the guest speaker at his sex ed class -- but he's too scared that if he stops the whole thing will be over. Ken keeps his eyes closed the whole time, but Brian doesn't care. He's wanted Ken for as long as he can remember.

After they both cum, Ken stands up and puts his clothes on quickly, and says, “You can go now.” He walks upstairs, leaving Brian stunned and embarrassed. That night, Brian sends Ken an email saying how confused he is, and that he hopes they can still be friends. Ken writes back a quick email saying he doesn't know what Brian's talking about, that he shouldn't talk like such a fag, and that he'll see him around at school.

For the next few days Brian avoids Ken. The following weekend, they're at the same party. Samantha isn't there, because she is away with her parents. There's a lot of alcohol, and Ken's surrounded by several different girls, including Samantha's best friend, LaShawn, who is hanging off him. When he sees Brian, he grabs LaShawn by the hand and walks her into one of the bedrooms in the house. Before they go in, another girl gets LaShawn's attention and tosses her a condom. She and Ken don't come out for an hour. Brian leaves, and drives into the city to go to a bar. He gets in with a fake ID, is picked up by an older guy, and ends up having sex in the guy's car. He's never had anal sex before, and it was fast and rough. He goes home feeling upset and confused, not knowing whether they used condoms. Still a little buzzed, he emails Samantha and tells her about LaShawn.

At school on Monday, Samantha storms up to Brian and tells him that she knows he came on to Ken and that Ken shot him down. She tells Brian that he should stop making up lies about LaShawn – that she'll never break up with Ken, and Ken will never want to be with him.

A week later, Brian is walking home, when Ken comes up to him quickly. “Look,” he says, “I have Chlamydia, ok? You gave me Chlamydia. Don't talk to me,” and takes off. Brian is freaked out, and goes in to the anonymous health clinic to get tested. The clinician asks Brian why he thinks he's at risk, and Brian says he doesn't know, he just wants to get tested. The clinician checks his watch, asks Brian how far he and his girlfriend have gone sexually, and then does the test. He passes two condoms over to Brian without looking at him, and gives him the phone number to call back for results.

The test comes back negative. Brian sends an email to Ken to let him know. Meanwhile, Samantha is over at Ken's house when the email comes in, and reads it. When Ken comes back into the room, she turns to him and asks, "Why is Brian telling you that he doesn't have Chlamydia? Did you tell him about my yeast infection?"

_____ Brian

_____ Samantha

_____ La Shawn

_____ Ken

_____ Clinic worker

Relationship Criteria

Type of Relationship: _____

What I'm looking for: _____

1. If I want to be sure we practice safer sex, I need to:

- _____
- _____
- _____

2. What might get in the way of my being able to practice safer sex?

- _____
- _____
- _____

3. What can I do if things seem to get in the way of my practicing safer sex?

- _____
- _____
- _____

4. If the other person STILL doesn't agree to practice safer sex, I can:

- _____
- _____
- _____

5. What might happen as a result of doing any or all of the things I wrote down in #4?

- _____
- _____
- _____

SESSION FIVE
“LESS FUN THAN YOU THINK – DRUGS, ALCOHOL AND SAFER SEX”

RATIONALE:

Experimentation with alcohol and illicit drugs is common during teen years. Among lesbian, gay, bisexual, or queer youth, alcohol and drug use is often common, due in great part to their experiences of homophobia, ambivalence about their orientation, stress or depression in dealing with relationships and/or being LGBQ, and more. This is especially true if an LGBQ teen is conflicted or has been in denial about their orientation, or if they are involved in a community that includes individuals who are of legal drinking age, and for whom drinking and using drugs are a part of their recreational and sexual activities. Far too many young people choose the short-lived high that can take place during a sexual act that includes alcohol or drug use, while far too many others are taken advantage of when under the influence of these substances. Although many LGBQ teens are familiar with the risk of HIV transmission posed by injection drug use, they tend to know less about the risks involved when mixing other types of drugs and/or alcohol with sex.

TIME:

2 hours

GOALS:

To help participants to:

- Learn basic information about common street drugs and alcohol.
- Understand and practice fast, smart decision-making when faced with a choice about drugs, alcohol, and safer sex.

OBJECTIVES:

By the end of this session, participants will be able to:

- Name at least three different kinds of drugs, and the category (stimulant, hallucinogen, depressant) under which each can be placed.
- Describe how drinking alcohol can impair one’s decision-making ability and coordination.
- Explain the decision-making process when one does not have much time in which to make a choice.
- Name at least two factors that come into play when a person is deciding whether to use drugs and alcohol and name at least two accompanying risks for STDs that accompany their decision.

MATERIALS:

- | | |
|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <input type="checkbox"/> Blank newsprint and easel or chalkboard/wipe-off board | <input type="checkbox"/> Handout, “Illicit Drugs Most Commonly Used by Teens” |
| <input type="checkbox"/> Markers or chalk appropriate for surface used | <input type="checkbox"/> Handout, Small Group Discussion Scenarios |
| <input type="checkbox"/> Masking tape | <input type="checkbox"/> Handout, Drug and Alcohol Risk Reduction Scenarios |
| <input type="checkbox"/> Stick pens | <input type="checkbox"/> 3 x 5” index cards, enough for each participant to have one |
| <input type="checkbox"/> Handout, “Basic Information on Most Commonly Abused Drugs” | |

ADVANCE PREPARATION:

Familiarize yourself with the information on the handouts about drugs and alcohol so that you will be able to answer questions from participants and to provide basic information as you discuss them throughout the session.

PROCEDURE:

Re-entry (10 minutes)

Remind participants of the last session's topic. Ask whether there are any questions left over from that session. If so, and they are more than a quick question-answer, write them up on the parking lot in order to have time to discuss them later.

Alcohol and Drug Overview (20 minutes)

1. Explain that today's session will be looking at drugs and alcohol, but from some unique perspectives. Ask, "How many of you know of a queer teen who drinks alcohol"? "How many of you know of a queer teen who uses illicit drugs?" Ask the group to look around the room and see how many people know someone who uses alcohol or drugs. Let them know that heterosexual teens use alcohol and drugs, too.

2. Ask, "What are some reasons why LGBTQ teens might use drugs and alcohol that might be different from reasons why straight teens do?" Record responses on newsprint or wipe-off board.

Probe for:

- Stress of not being out
- Stress of being out
- Worry about parents knowing
- Lots of other queer people do it; feels like part of the culture or social scene

3. Let them know that you are going to share some handouts with them at the end of the session that discuss really concrete information about different drugs and alcohol, but that you just want to highlight some basic facts before going into an activity about how drug and alcohol use relate to safer sex practices. Explain that this is a huge topic that would take many days to address

sufficiently, but that you are really going to focus very specifically on issues relating to STDs and safer sex.

4. On the newsprint or board, write three headings with enough space between them: “Stimulants”, “Depressants”, and “Hallucinogens”.

Ask what each term means, probing for:

- Stimulants are substances that increase heart rate and blood pressure.
- Depressants basically do the opposite and slow down reactions.
- Hallucinogens can cause people to see, hear, and feel things differently.

5. Go back to the list of drugs and alcohol and ask participants to classify each as a stimulant, depressant, or hallucinogen. Record their answers beneath the appropriate heading, using the following as a guide:

Stimulants -- Cocaine, Methamphetamines (Speed, Meth, Crystal, Crank, etc.), Ecstasy

Depressants -- Heroin, Alcohol, Barbiturates, Rohypnol

Hallucinogens – Marijuana, Ketamine (Special K), Acid, Mushrooms, LSD

Note to the Facilitator: *Be sure to review some of the slang names for different drugs, particularly club and party drugs, before the session. If you're in doubt of what the participants mean, be sure to ask them. An extensive list of drug and rave slang can be found online at <http://www.pride.org/slangdrugterms.htm>.*

6. Explain that drugs and alcohol affect how we react to things both physically and psychologically. That means that they cannot help but affect how we think about and practice safer sex. Tell the group that you will now do an activity demonstrating this.

“I’m Not As Think As You High I Am”:

The Impact of Drugs and Alcohol on Safer Sex (35 minutes)

1. Break the group into smaller groups of three. Distribute one of the “Small Group Discussion Scenarios” to each person in a group and ask everyone to read it, and think about how they would feel in that situation. Let them know that after they read the scenario, there will be a two-minute silence to give each person the opportunity to think about their own personal response, which they will share with the rest of their small group, to the extent to which they feel comfortable.
2. After a few minutes, ask the first person to start speaking. Let the rest of the group members know that they are not to talk or respond, but just to let the person talk until you have called time. After 5 minutes, call time, and ask the next person to read her or his scenario and then talk without interruption until time is called. Again, after 5 minutes call “time” and move on to the next group member. Continue until all group members have spoken.
3. After the last person has spoken, ask the participants to remain in their small groups, but to direct their attention back to you. Process by asking the following questions:

- How did it feel to do that? What was [insert participant responses] about it?
- What kinds of things went through your mind during those first few moments of silence after everyone had read their scenarios?
- How did it feel to share your thoughts and not have people respond?
- How might doing this activity help someone before they actually get into these or similar types of situations?

Risk Reduction: “What Would You Do If...?” (45 minutes)

Activity setup (15 minutes)

1. Break the group into pairs and make sure each pair has a piece of paper and pen or pencil. Explain that you are going to tell the group a brief story, and that you’d like them to listen carefully to all the details shared. Ask them not to write down anything until after you have shared the story.

Say:

“You are in a store, when a girl you know walks in with her girlfriend. They both have buzz cuts, have pierced lips, noses and eyebrows, and are wearing baggy pants with short-sleeved t-shirts. One t-shirt reads, ‘Bad grrrl’ and the other reads, ‘Yes, I am...’. They say hi to you, and walk down the aisle to pick some stuff up. Two large guys from school you know to be real jerks come into the store a few moments later. These guys are known for harassing girls in the hallway by touching their breasts and butts, and picking on the less popular kids in the school. They were also accused of beating up a guy last year who most people knew was bisexual, but there was no proof – the guy was attacked from behind and couldn’t identify them accurately.

The guys see the two girls and make a bee-line toward them. They stand behind them without touching them, and say, ‘You know, all some girls need is the right man to get them off that dyke thing... I wonder if these girls even know what a dick is...,’ and so on. The girl you know turns around and curses at one of the guys, takes her girlfriend’s hand, and tries to walk away, but the guys stand in her way. At the same time, the guys grab the girls, each putting a hand over one of their mouths.”

2. Explain that the pairs should, as fast as they can, list everything they could possibly do in this situation. Tell them not to censor themselves – that they shouldn’t worry about whether the idea seems outlandish or insensitive, or whether it is even illegal, but they should put down every possible thing they could do to respond to the situation. Let them know that once a pair has written down 6 items, they should stop and raise their hands.

3. Once a group has reached six, have them read off what is on their list. Record the list on the newsprint at the front of the room. Possible responses might include:

- Run and get the store owner for help.
- Call 911.
- Find an object and beat on one or both of the guys until they let the girls go.
- Take out a gun and shoot one or both of them.
- Walk away and pretend you didn't see anything, to avoid getting beaten up yourself.
- Hide in the store to avoid getting beaten up.
- Yell at the guys to distract them so the girls can get away.
- Tap one or both on the shoulder and try to talk sense into them.
- Pull the fire alarm in the store.
- Physically stand between one of the guys and the girl.

4. Go through the list with the group and ask them to eliminate any of the options that would be impossible or illegal – if, for example, a group wrote, “take out a gun and shoot them.” Go through the remaining items on the list have the group prioritize them based on how feasible, smart and likely each option is putting a star next to the one they determine to be the option they would most likely choose.

5. Ask, “*How did you decide what to do in this situation?*” Possible responses may include:

- We went as fast as we could.
- We thought about what would help them without us getting hurt.
- We just reacted – it was totally emotional.

6. Explain that, while decisions are often most effectively made when there is sufficient time and thought in which to make them, we are often faced with situations where we need to make a serious, possibly life-saving decision as quickly as possible. Explain that one way of doing this is to quickly make a list of all the possible options, just as you did together.

Small group activity (15 minutes)

7. Have the pairs join together to make small groups of four. Distribute one of the “Drug and Alcohol Risk Reduction Scenarios” to each group and ask them to do what you just did – brainstorm all the possible things the character can do in response, and then determine the final step she or he should take. Let them know they have about 10 minutes in which to do this.

8. After 10 minutes, have the groups that have the same scenarios (there are two) come together to compare their lists. Give them about 5 minutes in which to do this.

Activity Processing (15 minutes)

9. Bring the smaller groups’ attention back to the larger group, and process asking:

- What was it like to do that? What was [participant’s response] about it?
- What did you notice when you compared your ideas with the other groups’? Were there more similarities or more differences? Did doing this give your group any new ideas?

10. Read one of the scenarios and share what the two groups came up with as a response. Ask the other groups for their reactions, and whether they had any additional suggestions. Have someone from the other groups then read their scenario, share what they came up with, and ask for other feedback.

11. Process by asking:

- How did the type of drug in the scenario affect your decision-making?
- What other factors came into play as you were making your decisions? (Probe for: gender, body size, health, frequency of using the substance, how hot the person was, etc.)
- How might you be able to use what you learned from this activity in real life?

Closure (10 minutes)

1. Distribute small index cards and pens to each participant. Reiterate the fact that the topic of drugs and alcohol is huge, and that you only skimmed the surface during this session

Ask participants to think about and share what you did together in the session. Have them each write down one “take-home” message from this session about drugs, alcohol, and safer sex on their index cards, and ask for volunteers to share them. Record those on the board, supplementing as necessary with:

- People use drugs and alcohol, so even if you haven’t yet you may – or, at the very least, will be in situations where they are available to you.
- Drugs and alcohol do NOT mix with sex. If you’re going to be at a party where there will be drugs and alcohol, try to set up a buddy system so that you’re not alone with someone and won’t end up having sex with them under the influence.
- If you meet someone hot at a party, figure out a way to connect after the party when neither of you is high or drunk. Sex under the influence can be wild -- and it can also be terrifying, disappointing, abusive, and more.

2. Distribute the handout “Basic Information on Commonly Abused Drugs.” Tell participants that this handout contains some additional information that you did not necessarily cover in today’s session that they might want to have.

3. Thank participants for their work, and close the session. Remind participants of the time and place for the next session.

Handouts/ Facilitator Resources

SESSION FIVE

“Illicit Drugs Most Commonly Used by Teens”

Alcohol

Barbiturates

Cocaine

Ecstasy

Heroin

Ketamine (Special K)

LSD (Acid)

Marijuana

Methamphetamines (Speed, Meth, Crystal, Crank, etc.)

Mushrooms

Rohypnol

Basic Information on Most Commonly Abused Drugs

ALCOHOL

Alcohol is the most commonly used and widely abused psychoactive drug in the country.

What are the street names/slang terms for it?

Booze

What does it look like?

Alcohol is used in liquid form.

How is it used?

Alcohol is drunk. Types include beer, wine, and liquor.

What are its short-term effects?

When a person drinks alcohol, the alcohol is absorbed by the stomach, enters the bloodstream, and goes to all the tissues. The effects of alcohol are dependent on a variety of factors, including a person's size, weight, age, and sex, as well as the amount of food and alcohol consumed. The disinhibiting effect of alcohol is one of the main reasons it is used in so many social situations. Other effects of moderate alcohol intake include dizziness and talkativeness; the immediate effects of a larger amount of alcohol include slurred speech, disturbed sleep, nausea, and vomiting. Alcohol, even at low doses, significantly impairs the judgment and coordination required to drive a car safely. Low to moderate doses of alcohol can also increase the incidence of a variety of aggressive acts, including domestic violence and child abuse. Hangovers are another possible effect after large amounts of alcohol are consumed; a hangover consists of headache, nausea, thirst, dizziness, and fatigue.

What are its long-term effects?

Prolonged, heavy use of alcohol can lead to addiction (alcoholism). Sudden cessation of long term, extensive alcohol intake is likely to produce withdrawal symptoms, including severe anxiety, tremors, hallucinations and convulsions. Long-term effects of consuming large quantities of alcohol, especially when combined with poor nutrition, can lead to permanent damage to vital organs such as the brain and liver. In addition, mothers who drink alcohol during pregnancy may give birth to infants with fetal alcohol syndrome. These infants may suffer from mental retardation and other irreversible physical abnormalities. In addition, research indicates that children of alcoholic parents are at greater risk than other children of becoming alcoholics.

Source: National Institute on Alcohol Abuse and Alcoholism (NIAAA)

BARBITURATES

Barbiturates are prescription sedatives. Barbiturates that are commonly abused include amobarbital (Amytal), pentobarbital (Nembutal), and secobarbital (Seconal).

What are the street names/slang terms for it?

Barbs, Block busters, Christmas trees, Goof balls, Pinks, Red devils, Reds and blues, Yellow jackets

What does it look like?

Barbiturates come in multi-colored tablets and capsules.

How is it used?

These sedatives are used most often to treat unpleasant effects of illicit stimulants, to reduce anxiety, and to get "high". Short-acting barbiturates such as pentobarbital and secobarbital are the most frequently abused barbiturates. They are swallowed or injected. Commonly called "sleeping pills" or "downers" and often used on the street in combination with stimulants such as cocaine, amphetamines, and crystal meth/crank.

What are its short-term effects?

Slurred speech, shallow breathing, sluggishness, fatigue, disorientation, lack of coordination, dilated pupils. Barbiturates mimic alcohol inebriation causing mild euphoria, disinhibition, relief of anxiety and sleepiness. Higher doses cause impairment of memory, judgment and coordination, irritability, paranoid and suicidal ideation.

What are its long-term effects?

Tolerance develops quickly and larger doses are used, increasing the danger of an overdose. In an overdose or when taken with other drugs like alcohol, death is due to depression of the respiratory center in the brain. Withdrawal symptoms: Include tremors, elevated blood pressure and pulse, sweating, and possible seizures.

Source: Drug Enforcement Agency (DEA)

COCAINE

Cocaine is a drug extracted from the leaves of the coca plant. It is a potent brain stimulant and one of the most powerfully addictive drugs.

What are the street names/slang terms for it?

Cocaine: Big C, Blow, Coke, Flake, Lady, Nose candy, Snow, Snowbirds, White Crack, Freebase, Rock

What does it look like?

Cocaine is distributed on the street in two main forms: cocaine hydrochloride is a white crystalline powder and "crack" is cocaine hydrochloride that has been processed with ammonia or sodium bicarbonate (baking soda) and water into a freebase cocaine - chips, chunks, or rocks.

How is it used?

Cocaine can be snorted or dissolved in water and injected. Crack can be smoked.

What are its short-term effects?

Short-term effects of cocaine include constricted peripheral blood vessels, dilated pupils, increased temperature, heart rate, blood pressure, insomnia, loss of appetite, feelings of restlessness, irritability, and anxiety. Duration of cocaine's immediate euphoric effects, which include energy, reduced fatigue, and mental clarity, depends on how it is used. The faster the absorption, the more intense the high. However, the faster the absorption, the shorter the high lasts. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Cocaine's effects are short lived, and once the drug leaves the brain, the user experiences a "coke crash" that includes depression, irritability, and fatigue.

What are its long-term effects?

High doses of cocaine and/or prolonged use can trigger paranoia. Smoking crack cocaine can produce a particularly aggressive paranoid behavior in users. When addicted individuals stop using cocaine, they often become depressed. Prolonged cocaine snorting can result in ulceration of the mucous membrane of the nose.

Source: National Institute on Drug Abuse (NIDA)

CRYSTAL METH

Crystal Meth is a very pure, smokeable form of methamphetamine. It is an extremely addictive stimulant.

What are the street names/slang terms for it?

Ice

What does it look like?

Clear crystal chunks, like ice.

How is it used?

Usually smoked, sometimes snorted or injected.

What are its short-term effects?

Its effects are similar to those of cocaine but longer lasting. Crystal Meth can cause erratic, violent behavior among its users. Effects include suppressed appetite, interference with sleeping behavior, mood swings and unpredictability, tremors and convulsions, increased blood pressure, irregular heart rate.

What are its long-term effects?

Long-term effects can include coma, stroke or death.

Source: National Institute on Drug Abuse (NIDA)

ECSTASY

MDMA or Ecstasy (3-4-methylenedioxymethamphetamine), is a synthetic drug with amphetamine-like and hallucinogenic properties.

What are the street names/slang terms for it?

Adam, Bean, E, Ecstasy, M, Roll, X, XTC

What does it look like?

Ecstasy come in a tablet form that is often branded, e.g. Playboy bunnies, Nike swoosh, CK

How is it used?

Taken in pill form, users sometimes take Ecstasy at "raves," clubs, and other parties to keep on dancing and for mood enhancement.

What are its short-term effects?

Short-term effects can include involuntary teeth clenching, a loss of inhibitions, unusual displays of affection, transfixion on sights and sounds, muscle tension, nausea, blurred vision, and chills or sweating. After-effects can include sleep problems, anxiety and depression.

Ecstasy can cause severe dehydration, seizures and strokes. It can cause dramatic increases in body temperature and can lead to muscle breakdown, which can cause kidney failure. It can lead to liver and cardiovascular failure, which have been reported in some of the Ecstasy-related fatalities.

What are its long-term effects?

Repeated use of Ecstasy ultimately may damage the cells that produce serotonin, which has an important role in the regulation of mood, appetite, pain, learning and memory. There already is research suggesting Ecstasy use can disrupt or interfere with memory.

Source: National Institute on Drug Abuse (NIDA); Drug Enforcement Agency (DEA)

HEROIN

Heroin is a highly addictive drug derived from morphine, which is obtained from the opium poppy. It is a "downer" that affects the brain's pleasure systems and interferes with the brain's ability to perceive pain.

What are the street names/slang terms for it?

Big H, Blacktar, Brown sugar, Dope, Horse, Junk, Mud, Skag, Smack

What does it look like?

White to dark brown powder or tar-like substance.

How is it used?

Heroin can be used in a variety of ways, depending on user preference and the purity of the drug. Heroin can be injected into a vein ("mainlining"), injected into a muscle, smoked in a water pipe or standard pipe, mixed in a marijuana joint or regular cigarette, inhaled as smoke through a straw, known as "chasing the dragon," snorted as powder via the nose.

What are its short-term effects?

The short-term effects of heroin abuse appear soon after a single dose and disappear in a few hours. After an injection of heroin, the user reports feeling a surge of euphoria ("rush") accompanied by a warm flushing of the skin, a dry mouth, and heavy extremities. Following this initial euphoria, the user goes "on the nod," an alternately wakeful and drowsy state. Mental functioning becomes clouded due to the depression of the central nervous system. Other effects included slowed and slurred speech, slow gait, constricted pupils, droopy eyelids, impaired night vision, vomiting, constipation.

What are its long-term effects?

Long-term effects of heroin appear after repeated use for some period of time. Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, cellulites, and liver disease. Pulmonary complications, including various types of pneumonia, may result from poor health, as well as from heroin's depressing effects on respiration. In addition to the effects of the drug itself, street heroin may have additives that do not dissolve and result in clogging the blood vessels that lead to the lungs, liver, kidneys, or brain. This can cause infection or even death of small patches of cells in vital organs. With regular heroin use, tolerance develops. This means the abuser must use more heroin to achieve the same intensity or effect. As higher doses are used over time, physical dependence and addiction develop. With physical dependence, the body has adapted to the presence of the drug and withdrawal symptoms may occur if use is reduced or stopped. Withdrawal, which in regular abusers may occur as early as a few hours after the last administration, produces drug craving, restlessness, muscle and bone pain, insomnia, diarrhea and vomiting, cold flashes with goose bumps, kicking movements, and more. Major withdrawal symptoms peak 48 - 72 hours after the last dose and subside after about a week. Sudden withdrawal by heavily dependent users in poor health can be fatal.

Source: National Institute on Drug Abuse (NIDA) Drug Enforcement Agency (DEA)

KETAMINE

Ketamine hydrochloride is a central nervous system depressant and a rapid-acting general anesthetic. It has sedative-hypnotic, analgesic, and hallucinogenic properties. It is marketed in the US and a number of foreign countries for use as a general anesthetic in both human and veterinary medical practice.

What are the street names/slang terms for it?

Breakfast cereal, Date rape drug, Ketaject, Ketalar, New Ecstasy, Psychedelic heroin, Special-K, Super-K, Vitamin K

What does it look like?

Ketamine is a white powder, similar to cocaine.

How is it used?

Normally found in liquid injectable form, it is converted into a powder and re-packaged in small ziplock bags or capsules. Ketamine is generally snorted but is sometimes sprinkled on tobacco or marijuana and smoked. Special K is frequently used in combination with other drugs, such as Ecstasy, heroin and cocaine.

What are its short-term effects?

Effects can include profound hallucinations that include visual distortions and a lost sense of time, sense and identity. Other effects can include delirium, impaired motor function, potentially fatal respiratory problems, convulsions, and vomiting when mixed with alcohol and out of body experiences. A "K-hole" is the term users of ketamine use to describe an overdose experience

Source: National Institute on Drug Abuse (NIDA)

LSD

LSD is the most common hallucinogen and is one of the most potent mood-changing chemicals. It is manufactured from lysergic acid, which is found in ergot, a fungus that grows on rye and other grains.

What are the street names/slang terms for it?

Acid, Doses, Hits, Microdot, Sugar cubes, Tabs, Trips

What does it look like?

Colored tablets, blotter paper, clear liquid, and thin squares of gelatin.

How is it used?

LSD is taken orally and licked off blotter paper. Gelatin and liquid can be put in the eyes.

What are its short-term effects?

The effects of LSD are unpredictable. They depend on the amount taken, the user's personality, mood, and expectations, and the surroundings in which the drug is used. The physical effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, and tremors. Sensations and feelings change much more dramatically than the physical signs. The user may feel several different emotions at once or swing rapidly from one emotion to another. If taken in a large enough dose, the drug produces delusions and visual hallucinations. The user's sense of time and self changes. Sensations may seem to "cross over," giving the user the feeling of hearing colors and seeing sounds. These changes can be frightening and can cause panic.

What are its long-term effects?

Some LSD users experience flashbacks, recurrence of certain aspects of a person's experience without the user having taken the drug again. A flashback occurs suddenly, often without warning, and may occur within a few days or more than a year after LSD use. Most users of LSD voluntarily decrease or stop its use over time. LSD is not considered to be an addicting drug because it does not produce compulsive drug-seeking behavior like cocaine, amphetamines, heroin, alcohol, or nicotine.

Source: National Institute on Drug Abuse (NIDA) Drug Enforcement Agency (DEA)

MARIJUANA

Marijuana, the most often used illegal drug in this country, is a product of the hemp plant, *Cannabis sativa*. The main active chemical in marijuana, also present in other forms of cannabis, is THC (delta-9-tetrahydrocannabinol). Of the roughly 400 chemicals found in the cannabis plant, THC affects the brain the most.

What are the street names/slang terms for it?

Aunt Mary, Boom, Chronic, Dope ganja, Gangster, Grass, Hash, Herb, Kif, Mary Jane, Pot, Reefer, Sinsemilla, Skunk, Weed

What does it look like?

Marijuana is a green or gray mixture of dried, shredded flowers and leaves of the hemp plant (*Cannabis sativa*).

How is it used?

Most users roll loose marijuana into a cigarette called a "joint". It can be smoked in a water pipe, called a "bong", or mixed into food or brewed as tea. It has also appeared in cigars called "blunts".

What are its short-term effects?

Short-term effects of marijuana include problems with memory and learning, distorted perception (sights, sounds, time, touch), trouble with thinking and problem solving, loss of motor coordination, increased heart rate, and anxiety. These effects are even greater when other drugs are mixed with marijuana. A user may also experience dry mouth and throat.

What are its long-term effects?

Marijuana smoke contains some of the same cancer-causing compounds as tobacco, sometimes in higher concentrations. Studies show that someone who smokes five joints per week may be taking in as many cancer-causing chemicals as someone who smokes a full pack of cigarettes every day.

Source: National Institute on Drug Abuse (NIDA)

METHAMPHETAMINE

Methamphetamine is an addictive stimulant drug that strongly activates certain systems in the brain.

What are the street names/slang terms for it?

Chalk, Crank, Croak, Crypto, Crystal, Fire, Glass, Meth, Speed, White Cross, Tweek

What does it look like?

Meth is a crystal-like powdered substance that sometimes comes in large rock-like chunks. When the powder flakes off the rock, the shards look like glass, which is another nickname for meth. Meth is usually white or slightly yellow, depending on the purity.

How is it used?

Methamphetamine can be taken orally, injected, snorted, or smoked.

What are its short-term effects?

Immediately after smoking or injection, the user experiences an intense sensation, called a "rush" or "flash," that lasts only a few minutes and is described as extremely pleasurable. Snorting or swallowing meth produces euphoria - a high, but not a rush. After the initial "rush," there is typically a state of high agitation that in some individuals can lead to violent behavior. Other possible immediate effects include increased wakefulness and insomnia, decreased appetite, irritability/aggression, anxiety, nervousness, convulsions and heart attack.

What are its long-term effects?

Meth is addictive, and users can develop a tolerance quickly, needing larger amounts to get high. In some cases, users forego food and sleep and take more meth every few hours for days, 'binging' until they run out of the drug or become too disorganized to continue. Chronic use can cause paranoia, hallucinations, repetitive behavior (such as compulsively cleaning, grooming or disassembling and assembling objects), and delusions of parasites or insects crawling under the skin. Users can obsessively scratch their skin to get rid of these imagined insects. Long-term use, high dosages, or both can bring on full-blown toxic psychosis (often exhibited as violent, aggressive behavior). This violent, aggressive behavior is usually coupled with extreme paranoia. Meth can also cause strokes and death.

MUSHROOMS

Certain types of naturally occurring mushrooms contain hallucinogenic chemicals -- psilocybin and psilocin. These mushrooms are generally grown in Mexico and Central America and have been used in native rituals for thousands of years.

What are the street names/slang terms for it?

Caps, Magic mushrooms, Shrooms

What does it look like?

Dried mushrooms.

How is it used?

Mushrooms can be eaten, brewed and consumed as tea.

What are its short-term effects?

When ingested, mushrooms produce a syndrome similar to alcohol intoxication sometimes accompanied by hallucinations. Once ingested, mushrooms generally cause feelings of nausea and other physical symptoms before the desired mental effects appear. The high from using mushrooms is mild and consists of distorted perceptions. Effects may include different perceptions of stimuli like touch, sight, sound and taste. Onset of symptoms is usually rapid and the effects generally subside within 2 hours. The effects of mushrooms are unpredictable each time they are used due to varying potency, the amount ingested, and the user's expectations, mood, surroundings, and frame of mind. Effects can include sweating, nervous feeling, paranoia.

Source: Food and Drug Administration (FDA)

ROHYPNOL

Rohypnol is the brand name for a drug called Flunitrazepam, which is a powerful sedative. Rohypnol is not legally available for prescription in the United States, but is legal in 60 countries worldwide for treatment of insomnia.

What are the street names/slang terms for it?

Date rape drug, La roche, R2, Rib, Roach, Roofenol, Roofies, Rope, Rophies, Ruffies, The forget pill

What does it look like?

A small white tablet with no taste or odor when dissolved in a drink.

How is it used?

Rohypnol is swallowed as a pill, dissolved in a drink, or snorted. Roofies are frequently used in combination with alcohol and other drugs. They are sometimes taken to enhance a heroin high,

or to mellow or ease the experience of coming down from a cocaine or crack high. Used with alcohol, roofies produce disinhibition and amnesia.

What are its short-term effects?

The drug creates a sleepy, relaxed, and drunk feeling that lasts 2 to 8 hours. Other effects may include blackouts, with a complete loss of memory, dizziness and disorientation, nausea, difficulty with motor movements and speaking.

What are its long-term effects?

Rohypnol can produce physical and psychological dependence.

Source: National Institute on Drug Abuse (NIDA)

Small Group Discussion Scenarios

Scenario #1: You are at a party with some friends, who end up leaving early. You don't mind, because you've been talking with someone really cute all night. You've also been drinking, which is making you feel really confident. The person leans in and says it's hard to hear over the music, and suggests you go and talk in another room where it's quieter... You're a little confused when you wake up alone on a bed that's covered with people's coats, and find your clothes in a pile on the floor.

Scenario #2: You've been really interested in someone for a while and finally get up the nerve to ask them to come over to watch a DVD. When they say yes, you can hardly contain yourself. Your parents are away, and you're already keeping your fingers crossed for something sexual to happen. Not that you think it will necessarily go that far, but you have some latex planted strategically just in case. The night's going great – and halfway through the DVD, the person you invited over kisses you. As things get hotter and heavier, they say, “Wait, let's make this amazing.” They produce a small bag with powder in it, and ask if you've ever tried coke. You don't want them to leave, and say that you have, once. They offer you some, which you take, and which hits you like a ton of bricks. You fall asleep together, and when you wake up to use the bathroom in the middle of the night, you see the latex you'd planted still safely in its hiding place.

Scenario #3: You're with a group of people who are smoking pot, and decide to smoke some. You're feeling pretty mellow and happy, and someone really cute sits behind you and starts rubbing your shoulders. You take a walk together, and end up back at their home fooling around. They take out some latex and suggest you use it. You're feeling so good, you want to feel real, non-latex-covered sex, and tell the person you don't want to. They start to say something to you about herpes, and you kiss them to make them stop talking. After some really great sex, the person turns to you and says, "Listen, remember what I was trying to say to you about herpes? We really need to talk..."

Drug and Alcohol Risk Reduction Scenarios

Scenario A

Jordan

Jordan is a 15-year-old gay male who has only recently started coming out. He's excited about his identity and by the opportunities that being open about his orientation have given him. He's met a few queer people thanks to the gay-straight alliance at his school, and "Safe Space," an organization in his area for LGBQ teens.

Someone at Safe Space just told him about a party in the city that's taking place as part of pride week. Jordan's more excited than nervous, and decides to go. He has a fake ID and has always been told he looks older than he is, so he's pretty sure that he can get in, no problem. He figures that he'll know some of the people from Safe Space there, so even if he doesn't meet anybody, he'll have fun, although he's hoping to meet a really cute guy to hook up with.

When he gets to the party, the music is really loud. It's mostly guys in shorts with no shirts on, and they can dance really well. Right away, three different guys come up to him to dance. Jordan's a little intimidated – this is all so new to him!

He decides to take a break and goes into the bathroom, which is almost more crowded than the dance floor! He sees two of the guys he knows from Safe Space with two other guys who look like they're in their 30s. Jordan goes over to say hi and sees that they're snorting a white powder that he assumes is cocaine. His friends' eyes and nostrils are pretty red, and they tell him that he's got to try it – it's unbelievable to be high and then dancing at the party. Jordan looks at the two older guys, neither of whom seem to be snorting. One offers him the mirror and straw and says, "Check it out – what've you got to lose?"

What does Jordan want to happen tonight?

What are all the POSSIBLE things Jordan can do here?

What are the possible good things that could happen from each?

What are the possible bad things that could happen as a result of each?

Which options put Jordan at highest and lowest risk for STDs?

Which would you suggest Jordan do – and why?

Scenario B

Chantal

Chantal has been smoking pot since she was 14 years old, but only on and off. Now, at 16, she's started a relationship with a woman who's in med school named Amy. They met online, and connected immediately. After meeting in-person, they've been inseparable – at least when Amy can find time with her tough hours as part of her med school schedule.

Chantal's never been in love, and finds herself feeling like there's nothing she wouldn't do for Amy. She's only ever dated girls, but Amy's bisexual and says she still finds guys really attractive. Knowing this scares Chantal, but she doesn't let on because she wants Amy to think she's secure. Maybe then she'll let Amy know how old she really is; Amy thinks Chantal is 19.

Chantal goes over to Amy's apartment one night looking forward to some great sex and staying overnight. When she gets there Amy introduces her to a fellow med student named David. They are flirting with each other, and Chantal's feeling jealous – even after Amy kisses her and puts her arm around her on the couch. They order a pizza, and then David says, "Don't forget dessert," and pulls out a vial with some pills in it. He kisses Amy, and then looks at Chantal, who is furious. Amy whispers to Chantal, "What do you think? You've never been with a guy – it's really fun. Don't let this be a big thing – if you take a few of the pills you'll be so high, you won't even know that he's here. It'll just be like it's you and me."

What does Chantal want to happen tonight?

What does Amy want to happen tonight?

What are all the POSSIBLE things Chantal can do here?

What are the possible good things that could happen from each?

What are the possible bad things that could happen as a result of each?

Which options put Chantal at highest and lowest risk for STDs?

Which would you suggest Chantal do – and why?

SESSION SIX
“HEY! WHAT’S THAT SUPPOSED TO MEAN?”

RATIONALE:

Armed with a good understanding of the risks of STDs posed to them by unsafe sexual behaviors, drugs and alcohol, participants now need help in avoiding these potentially dangerous behaviors which are often encouraged through peer interactions and social pressure. Social learning theory recognizes that a critical component to behavior change is self-efficacy, the belief among participants that they are capable of performing the behaviors being asked of them. In this session, participants have the opportunity to practice using assertive communication in order to avoid sexual or other encounters that will put them at risk for an STD. As a closing to this program, students will have the opportunity to synthesize all they have learned in sessions one through six by coming up with creative ways of summarizing each of these sessions and presenting them to the large group.

TIME:

2 hours

GOALS:

To help participants to:

- Understand the difference between passive, assertive, and aggressive communication styles.
- Gain experience using assertive communication to avoid risky situations.
- Synthesize their learning from this program.

OBJECTIVES:

By the end of this session, participants will be able to:

- Label appropriately, as a large group, examples of passive, assertive, and aggressive communication styles.

- Provide, in small groups, appropriate suggestions for assertive communication that would help them to avoid a variety of potentially risky situations.
- Demonstrate, through role play, their ability to use assertive communication to avoid potentially risky situations.
- Display a synthesized understanding of the goals of this curriculum by creating, in small groups, creative representations of the most important learning from each session.

MATERIALS:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Newsprint <input type="checkbox"/> Markers <input type="checkbox"/> Masking Tape <input type="checkbox"/> Facilitator Resource: “Assertive Communication” <input type="checkbox"/> Handouts: “Nonverbal Assertiveness” <input type="checkbox"/> Newsprint, pre-printed with list of assertive statements <input type="checkbox"/> Facilitator Resource: Large group role-play scenarios <input type="checkbox"/> Facilitator Resource: Small group role play scenarios cut up into strips <input type="checkbox"/> Radio, tape player or CD player to play music | <ul style="list-style-type: none"> <input type="checkbox"/> Tape or CD of popular music for this audience (if using radio, find a station that plays the most popular music for this audience.) <input type="checkbox"/> Copies of facilitator’s outline for each session (to follow along during the ad presentations at the end) <input type="checkbox"/> Goals and objectives for each session <input type="checkbox"/> Poster board, markers, other art materials for students to create ads <input type="checkbox"/> Newsprint lists of hopes and concerns from session one <input type="checkbox"/> Evaluation forms for each participant. <input type="checkbox"/> Large envelope for evaluation forms. |
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ADVANCE PREPARATION:

1. Prepare newsprint with the following statements written on it:

- “I won’t have sex without a condom.”
- “I’m not going to do anything that’ll put me at risk for an STD.”
- “I will only have oral sex if we use latex.”
- “I don’t want to have sex while either of us is drunk or high.”

- “Please don’t ask me to do something I’m not comfortable doing.”
- “We need to talk about our risk for HIV and other STDs before we do anything sexual.”

2. Photocopy the goals and objectives for each session of this curriculum.

3. Photocopy the facilitator’s outline for each session of this curriculum.

PROCEDURE:

Re-entry (5 minutes)

Welcome participants back to the sixth and final session. Go around the group quickly and ask if anyone has any thoughts about the last session they would like to share.

Passive, Assertive, Aggressive, Communication (10 minutes)

1. Say to the group

“We have spent a lot of time looking at the risks of HIV and other STDs to LGBTQ youth, and providing reasons and methods for avoiding these risks. Unfortunately, making up your mind not to do something isn’t always good enough. Avoiding situations that could be risky is very important. For example, if you are invited to a party where you know there will be no adults and where there is a good chance drugs and alcohol will be present, it’s very possible that sex will be a factor. No matter how strongly we may feel about our choices and convictions, we all know how hard it can be to resist behaviors we know could be bad for us in the face of intense persuasion by other people, including our friends, or even people we may not know.”

Explain to the group that even if they are able to avoid going to that party you just talked about, sometimes situations come up that are unexpected. Say,

“In these situations, we still need to find a way to avoid those behaviors that we know are bad for our health and well-being. In order to do that, all of us need to be able to communicate our intentions clearly and completely. This is not always as easy as it sounds, however.”

2. Ask “*What can sometimes make it difficult to communicate to someone that you either want to practice safer sex with them – or that you are not interested in doing something sexual with them at all?*” Record responses on newsprint.

Some possible responses might include:

- “I don’t want to look uncool.”
- “I like them.”
- “I want them to like me.”
- “Our friends know each other and it’d get back to them.”
- “If I bring up safer sex, they won’t want to have sex.”
- “I don’t know how to say it.”
- “These things usually aren’t talked about, they just happen.”

3. Say,

“While these are all reasons why people are often unable to communicate their desire to practice safer sex or not to participate in some activity or behavior, we still need to be able to find a way to do this effectively in order to avoid getting into situations in which we don’t want to be. In learning how to communicate effectively, it is important to remember that HOW we express ourselves is just as important as WHAT we are trying to communicate. Different styles of communication typically get different results. These styles include passive, assertive, and aggressive communication styles.

*“Being **PASSIVE** is when a person is timid or unclear in expressing his/her needs – or when the person won’t speak up about what he or she wants or doesn’t want, but just goes along with what the other person or the group wants.*

*“Being **AGGRESSIVE** is when a person tries to get what he or she wants by bullying the other person or people into it.*

*“There is another kind of communication called **PASSIVE AGGRESSIVE** which is when someone uses what seems like a passive expression but with aggressive or malicious intent. People use passive-aggressive communication when they want to express anger but don’t want to have to be responsible for that anger, so they can deny being angry. This kind of communication may include any number of nonverbal behaviors including sighing, rolling of the eyes, etc. This type of communication can be extremely frustrating for others to deal with because it is not direct; the person communicating is not willing to be honest about what is bothering him/her.*

*“Being **ASSERTIVE** is when a person says what he or she wants or means without being hurtful to the other person or to the group. This is typically the clearest and most effective form of communication one can use, although it is not always easy to carry out.*

“Let’s look at a straightforward example. What if you are with a group of friends deciding what kind of food to order in (and chip in for) for “movie night” at one friend’s house. One person suggests a type of food that you really don’t like to eat. Two or three others support the suggestion.

Ask: *“If you were **PASSIVE**, how might you react?”*

Some possible responses might include:

- “I’d just go along with the group and then not eat.”
- “I’d say, ‘That’s not really my favorite but if that’s what everyone else wants, I’ll eat it.’”

Ask: *“Is that an effective way of responding? Why or why not?”*

Possible responses might include:

- It’s not, because you would end up not eating anything.
- It’s not, because you would end up eating and chipping in for something you don’t like.

Ask: *“How might you respond to this suggestion if you were **AGGRESSIVE**?”*

Possible responses might include:

- “I wouldn’t eat that food if my life depended on it.”
- “If you order that food, don’t count on my money.”
- “I’ll chip in but only if we order what *I* like!”

Ask: *“Is this an effective way of responding? Why or why not?”*

Possible responses might include:

- It’s not, because it shows that I only care about what I want and am not considering anyone else’s needs.
- It’s not, because it is just going to get my friends mad and doesn’t help us find a solution.
- It’s not, because it can make people feel bad. It’s rude.

Say:

“In most situations, neither passive, nor aggressive ways of communicating are most effective. Sometimes, people use the words of passive communication but in a very aggressive way. This is called passive aggressive and it is just as inadequate in reaching the goal of good, clear communication. An example of a response to this situation that is passive aggressive might be:

‘Fine. I’ll go along with the group. Clearly, what I want really isn’t important to you, but that’s okay.’

In this situation, the actual words seem very passive, but the way the person says it is designed to make the rest of the group feel guilty—or bullied-into doing what the person wants to do.”

Ask: *“Can you think of another example of a passive aggressive response to this situation?”*

Possible responses might include:

- “It’s okay. I don’t need to eat anyway.”
- “Don’t worry about me. You guys figure out what you want, I’m used to giving in.”
- “Whatever.”

Ask: *“Is this an effective way of communicating? Why or why not?”*

Possible responses might include:

- “It’s not, because you might get what you want but your friends feel manipulated.”
- “It’s not, because you don’t give your friends a chance to discuss options. You are giving an ultimatum.”

Ask: *“How would you respond to the same situation if you were ASSERTIVE?”*

Possible responses might include:

- “That’s not really a kind of food I like. Is there another type that we can all agree on?”
- “I don’t eat that kind of food but I’d be open to other suggestions.”

Ask: *“Is this an effective way of responding? Why or why not?”*

Possible responses might include:

- “It is, because you are stating your preference while respecting the choices of others.”
- “It is, because everyone’s needs are equally important.”

5. Distribute to each participant the handout “Assertive Communication.” Go over examples on handout and answer questions participants may have.

Non-Verbal Communication (10 minutes)

1. Say:

“That was a really good overview of the kinds of verbal expressions we can use to communicate. In real life situations, though, we communicate with much more than our words, right? What are some other ways that we communicate?”

Possible responses might include:

- Facial Expressions
- Tone of Voice
- Body Language
- Symbols

Say:

“These are all examples of non-verbal communication. Non-verbal communication can be just as important in sending a message as what we actually say. Among people who identify as LGBTQ, there is a particularly good understanding of the importance and meaning of non-verbal communication. Historically, living in homophobic societies, queer folks have had to find ways to communicate with one another often with non-verbal signals, or in verbal codes - and without non-queer people noticing - that let each other know they are LGBTQ. Can we think of some examples of these kinds of signals? How do you figure it out that someone else is lesbian, gay, bisexual, or queer without talking to that person?”

Give participants an opportunity to share responses.

Possible responses might include:

- Certain types, brands or styles of clothes
- Wearing certain kinds of jewelry
- Eye contact that lasts just a second longer than usual
- Making reference to certain kinds of music or artists.
- Flags, symbols, etc.

Say:

“While some of what we just talked about reinforces stereotypes, in some situations, non-verbal communication is the primary mode of communicating a message, such as when you are somewhere where there is loud music playing, or a very crowded room where there is a lot of talking. When you are unable hear the other person or hear yourself, for that matter, your non-verbal signs are even more important. Even when we are talking, however, our body language can help or hurt our message.”

2. Distribute the “Nonverbal Assertiveness” handout. Go over the examples and answer any questions.

3. Divide participants into small groups of 4-5. Assign each group to be either passive, aggressive, or assertive. (If there are more than three groups, assign the same category to more than one group, but make sure that “Assertive” gets repeated before either of the other two categories.) Tell the groups that you are going to give them a list of assertive statements regarding safer sex that they are to say. In the assertive group, their body language, including facial expressions, posture and other non-verbal messages, are to match their assertive statements with equal assertiveness. In the passive group, their body language and other non-verbal messages should demonstrate passive communication while they are speaking their assertive statement. In the aggressive group, they should communicate aggressive non-verbal communication while speaking their assertive statement. Tell each group that they can divide up the statements so that each person gets to show one to the large group. They will have just two minutes to plan their gestures and other non-verbal communication and to discuss them with their group.

4. . Have the following statements on newsprint to show to the group:

- “I won’t have sex without a condom.”
- “I’m not going to do anything that’ll put me at risk for an STD.”
- “I will only have oral sex if we use latex.”
- “I don’t want to have sex while either of us is drunk or high.”
- “Please don’t ask me to do something I’m not comfortable doing.”
- “We need to talk about our risk for HIV and other STDs before we do anything sexual.”

Allow two minutes for participants to plan how they present their statements. After time is up, go around to each group, one at a time for each statement. So, for statement one, have a member of the passive group say the statement while demonstrating passive non-verbal communication. Next go to the aggressive group and have a member say the same statement while demonstrating aggressive non-verbal communication. Last, go to the assertive group and have a member say the same statement while demonstrating assertive non-verbal communication. Do this for each statement.

Note to the Facilitator: *If there are not enough people, have some people go twice or use the number of statements from the list below that will be appropriate for your group size and time available.*

5. After all of the statements have been demonstrated, process the activity by asking:

- What was it like to do that activity?
- What did you notice about the different effects of non-verbal communication?
- Which method gave the clearest message?
- How can inconsistent verbal and non-verbal messages affect a person's ability to communicate clearly?

Say

“Okay, so now that we have some guidelines about verbal and non-verbal assertive communication, we are going to put it all together and practice communicating assertively through role plays.”

Role Playing Refusal/Negotiation/Safer Sex Communication Skills (50 minutes)

Large Group Role Play (25 minutes)

1. Tell the group that you are going to ask for two volunteers to begin the role play. You will present the scenario and then ask the two volunteers to act it out as person “A” and person “B”. The goal for person “B” will be to negotiate a solution that keeps him/her safe from the risk of STDs/HIV by sticking to assertive communication. After one minute, if one of the “players” gets stuck, someone else who thinks they have a good solution can raise his/her hand, and with permission of the facilitator, take the person's spot and continue the dialogue as if it had never left off. As each person takes a turn in the role-play, participants should give him/her time to think the situation through and not replace him/her too quickly. (It will be up to the facilitator to make sure this happens.)

Tell the group that the scenarios may involve only males, only females or a mixture of genders but that anyone can step in to the role play. Ask for two volunteers. Read the role play to the entire group then have the volunteers begin to act out the scene.

As they begin, encourage person “B” to use assertive communication skills. As the role play continues, if either person gets stuck allow other participants who raise their hands to take one of the players’ places and continue the dialogue.

Once the role play has reached a satisfactory conclusion (both players agree to a solution, or one person closes the dialogue) or after about five minutes (or if the conversation is going nowhere) stop the role play.

Note to the facilitator: *It is possible that your group may not volunteer to “save” players whose scenario is not going well, or who get “stuck” in their role play. Be prepared to stop the scene if necessary and ask the group specifically for some ideas or suggestions – or even for other volunteers to jump in to take over one or both of the roles.*

2. Thank all of the players and have them return to their seats. Process the activity by asking the following questions:

- What did you notice about the conversation you just witnessed?
- What were some strategies you saw or heard from person “A” that you thought were particularly effective?
- What were some strategies you saw or heard from person “B” that you thought were particularly effective?
- What non-verbal communication did you notice?
- What might have been some other things person “B” could have done or said in this situation?
- Are there some situations where a person might HAVE to use aggressive communication? When? Why might the consequences be of doing that?

3. If time allows, ask for two more volunteers to do a new scenario.

Note to the Facilitator: It is important to keep to the time limit of 25 minutes for the large group role-play in order to allow 25 minutes for the small group role play. Do not begin a new scenario if there is not enough time to complete it.

Small Group Role Play (25 minutes)

1. Tell participants that they will now have some time to practice negotiating about safer sex in small groups. Break up participants into groups of three. Each group should pick a person “A”, person “B” and an observer for the first round. Tell them they will have three rounds, so that each person will get to play each role.
2. Hand out the scenarios to each person (all groups will get the same scenario). Person “A” will only get the person “A” part of the scenario, however. Person “B” will get his/her corresponding role, and the observer gets the overview of the scene that he/she is to read to the other two participants to set the scene. Give the groups three minutes to role play. Call time and have the groups talk for two minutes about how the dialogue went beginning with the observer sharing what he/she observed.
3. Repeat the activity with a new role play. Have participants rotate roles so there is a new Person “A,” Person “B,” and observer. Again, allow three minutes for role playing and then two minutes for feedback in small groups.

Note to the Facilitator: For the second scenario, put on some music in the background (either a tape or CD) to simulate a very loud party or other loud setting. Have participants role play within this setting. Because it will be loud, participants will not be able to hear the dialogue very well. Tell players that they will have to rely on non-verbal communication even more than in the last scenario. Because it will be difficult for participants to hear, keep this scenario short.

4. Repeat one more time so that every person gets a chance to play each role.
5. After the third round, process the activity by asking the group:

- What was it like to do this activity?
- What was the most challenging part of the role-playing?
- Did anyone find particular strategies that they think would be useful?
- How would these scenarios be different if, instead of in person, they were through instant messaging or on the internet?
- What non-verbal communication did you notice?
- How does being in a very loud place affect your ability to negotiate/communicate about safer sex?
- How does practicing in role-plays like this affect your ability to communicate effectively in real life?

Putting It All Together (30 minutes)

1. Tell the group that you have now come to the end of the sixth and final session of the program. It is time to think about everything they have talked about and learned and to put it together, to synthesize it into a bigger picture of what it all means to them. Tell participants that they are going to create advertisements for LGBTQ teens that represent some of the major concepts of this program.

2. Break up participants into groups of no more than four each. Assign each group a major concept from this program from the list below and provide them with the handout listing the objectives of that session. Tell participants that they can be as creative as they like. They can create a print ad using the various art supplies that are available, or they may create a radio or television spot that they can perform for the group. The groups will have fifteen minutes to work on their ads. The ad should use one or more of the main points from the concept they are assigned and should be as persuasive as possible. Each group will then have the opportunity to perform or display their advertisement.

3. During their planning time, go around to the groups and provide help and ideas if needed. When there are two minutes remaining, give participants a time warning so that they will be ready to go.

4. At the end of fifteen minutes ask for groups to volunteer to demonstrate their ad. After everyone has finished give a round of applause and offer appreciation to all the groups for their ads.

Note to the Facilitator: *The ideal number of groups for this activity is six, one for each session of the program. If there are not enough participants for each group to have at least three members (18 participants all together), then select only some of the sessions to be represented. After all of the ads have been displayed or presented, ask the group to think together of what the main concepts were from the session(s) that was not covered. If the group is too large for there to be only four participants per group, have more groups and assign the same session to more than one group. In order to have enough time to present all of the ads with a large group, you may need to cut down on preparation time.*

CONCEPTS FOR ADVERTISEMENTS

SESSION 1 “So what do STDs Have to do with Me?”

SESSION 2 “Well, Waddya Know?”

SESSION 3 “Making Safer Sex Fun”

SESSION 4 “Practicing Safer Sex”

SESSION 5 “Less Fun Than You Think – Drugs, Alcohol, and Safer Sex.”

SESSION 6 “Hey! What’s That Supposed to Mean?” Assertive Communication

Note to the Facilitator: *Depending on how long a period of time has transpired over the course of the program, participants may need more than just the titles of the sessions to help them to remember the concepts. Feel free to provide participants with the facilitators outline of each session or, at a minimum, a copy of the goals and objectives for each session, if they need some assistance.*

Closure (10 minutes)

1. Display for the group the newsprint lists with their hopes and concerns about the program from the first session. Ask participants for reactions about the extent to which their hopes and/or their concerns were realized through the program.
2. Ask participants to stand in a circle (you can ask them to hold hands if it is appropriate for this group.) Ask participants to share one thing that they really have appreciated about this group or this program. Participants should feel free to speak when they like. There is no need to go in order and no one is required to speak. Make sure, though, to leave silences long enough to provide the opportunity for anyone who wants to say something to be able to do so.
3. After everyone has had a chance to share an appreciation go around the group again, this time in order, and ask each person to share one thing they will do or do differently as a result of this program.

Note to the facilitator: *Be sure that you are the last to go, acknowledging the work and achievements of the group. Avoid singling out any members but rather focus on the group itself. Feel free to share how working with the group has been for you, and remind the group that, although they will continue as individuals and, possibly, a group if this is an ongoing program, this experience is over, and they should feel proud of what they accomplished together. Wish them well, and offer a moment of silence to reflect on what is to come.*

Evaluation (5 minutes)

Distribute evaluation forms to participants. Ask them to fill them out anonymously and to place them in the envelope placed in the front of the room.

Handouts/ Facilitator Resources

SESSION SIX

Assertive Communication

Assertiveness is the ability to express your opinions, feelings, attitudes, and rights, honestly, in a way that doesn't infringe on the rights of others. Most people find it easier to be assertive in some situations than in others. This makes perfect sense. It's a lot easier to hold your ground with a stranger than with someone you love who might get angry if you express your true feelings. But the more important the relationship is to you, the more important it is to be assertive. Assertive behaviors lead to increased respect from others, their willingness to see you as a person who respects him/herself, a *worthwhile* person, a more loveable person!

Is assertiveness always the best way to go? Before deciding to act assertively in a given situation, a person has to decide if she/he can live with the consequences. Although assertive behavior usually will result in a positive response, some people might react negatively to it.

Techniques for Effective Assertive Communication:

1. Use Assertive Body Language: Face the other person, stand or sit straight, don't use dismissive gestures, be sure you have a pleasant, but serious facial expression, keep your voice calm and soft, not whiney or abrasive.

2. Use "I" statements. Keep the focus on the problem you're having, not on accusing or blaming the other person. **Example:** "I'd like to have a good time with you without having to worry about STDs." instead of "You're always trying to get me to do risky things!"

3. Use facts, not judgments. Example: "You have asked me to do shots with you six times" instead of "You keep nagging me." or "Did you know that getting drunk can interfere with being able to get an erection?" instead of "Have one more drink and you'll never get it up!"

4. Express ownership of your thoughts, feeling, and opinions. Example: "I get angry when don't respect my needs" instead of "You make me angry." or "I believe the best thing for us is to..." instead of "The only sensible thing is to ..."

5. Make clear, direct, requests. Don't invite the person to say no. **Example:** "Will you please?" instead of "Would you mind ... ?" or "Why don't you ... ?"

Additional techniques for difficult situations:

- **Broken record:** Keep repeating your point, using a low level, pleasant voice. Don't get pulled into arguing or trying to explain yourself. This lets you ignore manipulation, baiting, and irrelevant logic. **Example:** You are having sex with someone you don't know very well. You tell them that you only have protected sex but they question your decision and try to imply that there is something wrong with you because, after all, the risk at your age for an STD is incredibly small and you are just being paranoid. Using the *broken record*, you say "I only have protected sex." Then, no matter what the other person says, you keep repeating, "I only have protected sex." If he/she doesn't get it, keep

repeating it until they agree to have protected sex, or until one or both of you choose to walk away. This really works!!

- **Fogging:** This is a way to deflect negative, manipulative criticism. You agree with some of the fact, but retain the right to choose your behavior. **Example:** Girlfriend: "Why do we need dental dams? Hardly anyone uses them, they are so hard to get." You: "You're right, they are hard to get." Agree with as much of the facts as you want to, but don't agree to changing your mind about the dental dam. *Fogging* is great for avoiding fights and making people stop criticizing. With significant others, sometimes it's best to quietly hear them out, then assertively give your response.
- **Content to Process Shift:** This means that you stop talking about the problem and bring up, instead, how the other person is behaving RIGHT NOW. Use it when someone's not listening or trying to use humor or a distraction to avoid the issue. **Example:** "You're getting off the point. I'm starting to feel frustrated because I feel like you're not listening."
- **Defusing:** Letting someone cool down before discussing an issue. **Example:** "I can see that you're upset, and I can even understand part of your reaction. Let's talk about this later." Also, if they try to stay with it, you always have the right to walk away.
- **Summarization:** This helps to make sure you're understanding the other person. **Example:** "So what you're trying to tell me is"
- **Specificity:** It's really important to be very clear about what you want done. This helps prevent distractions. **Example:** "The thing I really wish is that you'd stop asking me to have unsafe sex."

AN IMPORTANT NOTE ABOUT CULTURE

Culture plays a very big role in the interpretation and use of assertive communication. Different norms regarding the appropriate degree of assertiveness in communicating can add to cultural misunderstandings

Assertiveness. American culture generally favors assertive communication as the most effective approach to problem solving or conflict resolution. It is important to recognize that different cultures, and sub-cultures within the United States have very different interpretations of assertive behavior. People may be offended by communicators who are more assertive than is acceptable in their culture.

Candor: In some cultures, expressing one's true feelings is essential and respected. In other cultures, people are not less honest, but have their own different ways of expressing their true feelings that may be less direct or non-verbal. Cultures will also differ on what situations are appropriate for sharing true feelings and strong opinions.

Volume: Some White Americans typically consider raised voices to be a sign that a fight has begun, while some African-American or Black, Jewish and Italian Americans often feel that an increase in volume is a sign of an exciting conversation among friends. Thus, some White Americans may react with greater alarm to a loud discussion than would members of some American ethnic or non-White racial groups.

Nonverbal Assertiveness

In everyday conversation, spoken words are only one way to communicate. As little as 7 percent of a message may be expressed in words. The rest is through facial expression, voice tone, body gestures, and overall posture. When the verbal and nonverbal messages don't match up, people pay more attention to the nonverbal message. That's what's meant by the old saying, "A picture is worth a thousand words." Awareness of our nonverbal behaviors is important especially when we are in a situation where the noise level makes verbal communication difficult (when there is loud music playing or in a very crowded room, for example.) In these situations, often non-verbal communication becomes the most important way of getting your message across and being "heard."

ELEMENTS OF NONVERBAL ASSERTIVE COMMUNICATION

- 1. Eye contact.** Direct eye contact is assertive. Looking directly at another while you are speaking strongly suggests, even demands, that you be listened to and taken seriously. Maintaining eye contact while the other is speaking shows your interest in listening.
- 2. Posture.** An erect and relaxed posture while standing and sitting communicates confidence, self-control, energy and an expectation that you be taken seriously. When sitting, leaning forward slightly communicates interest and a sense of purpose. Crossing your arms and legs suggests a tense and closed attitude while uncrossed arms and legs suggests a relaxed and open attitude.
- 3. Facial expression.** Our face tells others the degree to which we are alert, interested, in agreement, or relaxed. It reveals the types of emotions we feel. It is best to keep your facial expression as neutral as possible.
- 4. Gestures.** Gestures can be used to accentuate and support your message or to distract and discredit. Hand and arm movements can be used to emphasize what you say. Do not emphasize everything, however. Keep your gestures relaxed, fluid and moderate in size.
- 5. Tone of Voice.** There are many aspects of voice that affect the impact your words have on others. The most important of these and the easiest to control are loudness and speed. Speak loudly and slowly enough to be heard and understood. Raising the pitch of your voice at the end of a sentence makes the sentence sound like a question. A slight lowering of pitch at the end of a sentence makes it sound like a statement. Make your statements sound like statements in order to strengthen your message.

THE IMPACT OF CULTURE ON COMMUNICATION

It may be difficult to understand nonverbal messages because different cultures have different expectations about eye contact, physical touch, body gestures, etc. A person's gender, age, level of acculturation, and individual preference can all have an impact on communication styles.

Eye Contact

While Americans are taught to maintain regular eye contact during conversations, and refusing to look someone in the eye may be understood as lack of trust, or maybe boredom, people of other cultures are taught that too much eye contact can offend or sometimes have romantic or sexual connotations. Others are taught to avoid direct eye contact, as that is considered a weakness.

Physical Contact

Culture greatly influences attitudes about physical contact, whether it's a handshake, hug, or pat on the back. Cultures vary in the extent to which physical contact is allowed and between whom. In low-contact cultures, including British and other northern European cultures as well as Japanese culture, touch occurs only under restricted conditions, such as within the family and in close relationships, sometimes in greetings, and in certain specified settings such as health care. Touch in other situations can cause great anxiety and tension. It is seen as imposing upon a person's privacy. In contrast, in high-touch cultures, physical contact is seen as friendly and positive. People may touch frequently while they talk. When people from cultures with different touch levels interact, the low-contact person may be seen as aloof, cold and unfriendly, whereas the high-contact one may be seen as intrusive and even perverted

Personal Space

How close should people stand to each other when they're having a conversation? Many people of Middle-Eastern or South American cultures, stand very close when talking. European Americans like to have more distance between them, while some African Americans prefer even more space. You can create great discomfort by standing too close to another person. Not being aware of this can even prevent someone from understanding or accepting the ideas you're trying to get across.

LARGE GROUP ROLE PLAY SCENARIOS

Choose one or more of the following scenarios

1. Person A and Person B have been together for a while and have decided to start being more sexually intimate. Person A just wants to do it and not talk about it so much. Person B wants to talk about what they each want to do, what their limits are and safer sex.
2. Person A and Person B have recently met and are going out for the third time. So far all they have done is make out. Person A is ready to take it to the next step. Person B is not sure she/he is ready for it just yet.
3. Person A and Person B are a couple. Person A wants to experiment with drugs because he/she heard that sex is so much better that way. Person B is very curious but is really afraid to try drugs for a whole lot of reasons.

SMALL GROUP ROLE PLAY

SCENARIO 1

O. Dawn and Debra: You have been seeing each other for three months and lately things have been really heating up. From the minute you saw each other tonight you knew this was going to be a big night. The two of you just got home from a party at which you were flirting with and coming on to each other all night. You both know that tonight is the night sex is going to happen. You are at Dawn's parents' house but no one is home tonight. You have the place to yourselves.

A. Dawn: No matter what Debra says, you are going to seduce her, you are ready for sex and you won't let the night end without it. You have never used any kind of protection and don't ever plan to because you have only ever been with other girls, and you know that lesbians are at extremely low risk for HIV/STD transmission. Besides, it really ruins the mood and the spontaneity.

B. Debra: You have been waiting all night for this moment. You are ready to go but you have recently learned about the risks of STD/HIV transmission and want to make sure anything you do is safe. While you don't particularly want to discuss it with Dawn, you have been with a few other people before her including both guys and girls and you once contracted Chlamydia, which wasn't fun at all. You just don't want to go through that again.

SMALL GROUP ROLE PLAY

SCENARIO 2

O. Jeff and Ralph: You just met each other earlier tonight at this party. Though the music and talking are very loud making it very difficult to have a normal conversation, you have both managed to let the other one know that you are attracted to each other.

A. Jeff: You are ready to make out right here in the middle of the crowd. This is the hottest guy you have met in a long time. You are ready to get physical NOW!

B. Ralph: Jeff is really cute. He is exactly your physical type although it is hard to tell if he is your type other than that because you can't really talk to him. You certainly want to get to know him better but you are feeling a little bit drunk and you don't trust yourself to start something you won't have control of. You are not ready to get physical with him tonight but would like to go out together another night to a quieter place where you can talk and get to know one another.

SMALL GROUP ROLE PLAY

SCENARIO 3

O. Robin and Corey: You have been going together for six months and have been sexually active for the past five months. You are both very happy in the relationship.

*****A.

Corey: Ever since you both went and got tested for HIV and other STDs you have not been practicing safer sex. No need to. Not using latex makes you feel so much closer and more intimate with Robin.

B. Robin: Although you really like Corey and love the sex, you have not been completely faithful these past two months. First it was just a one night fling but in the past two weeks you have started seeing someone else on a more regular basis and you haven't been totally safe all the time. You care about Corey a lot and don't want to bring your indiscretions into this relationship. You want to go back to practicing safer sex for your own sake, and Corey's. And besides, can you really be sure Corey isn't playing around on you too?