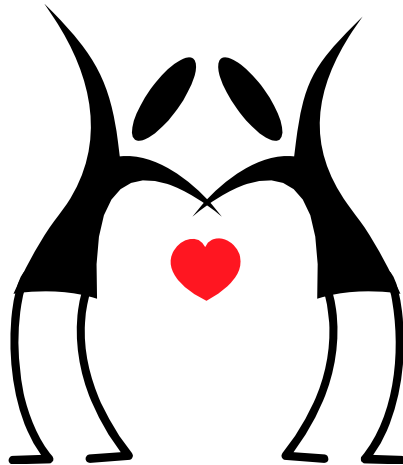


Based on
**TCU Mapping-Enhanced Counseling
Manuals for Adaptive Treatment**

As Included in NREPP



COMMON SENSE IDEAS FOR HIV PREVENTION AND SEXUAL HEALTH

**A collection of materials for leading counseling sessions that
address knowledge and skills to reduce HIV and other STD risks**

N. G. Bartholomew and D. D. Simpson
Texas Institute of Behavioral Research at TCU
(August 2005)

TCU Mapping-Enhanced Counseling manuals provide evidence-based guides for adaptive treatment services (included in the National Registry of Evidence-based Programs and Practices, NREPP, 2008). They are derived from cognitive-behavioral models designed particularly for counselors and group facilitators working in substance abuse treatment programs. Although best suited for group work, the concepts and exercises can be directly adapted to individual settings.

When accompanied by user-friendly information about client assessments that measure risks, needs, and progress over time, *TCU Mapping-Enhanced Counseling* manuals represent focused, time-limited strategies for engaging clients in discussions and activities on important recovery topics. These materials and related scientific reports are available as Adobe PDF® files for free download at <http://www.ibr.tcu.edu>.

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TCU MAPPING-ENHANCED COUNSELING MANUALS
FOR ADAPTIVE TREATMENT
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AND SEXUAL HEALTH

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Part 1:

HIV Update

HIV Update is part of the *Approaches to HIV/AIDS Education in Drug Treatment* manual developed at TCU. This session features a leader's script, handouts, and a participant activity for leading a session on basic HIV information and personal risk taking. Participants are invited to think about risk experientially and to talk with others in their social network about HIV risks. Discussion questions encourage thoughtful reflection about personal risk.

Source: TCU / Institute of Behavioral Research. From treatment manual *Approaches to HIV/AIDS Education in Drug Treatment*

Session Preparation Notes

Node-link Information Maps as discussion guides

HIV/AIDS information in a “map” format is provided at the end of the session. Maps can be used as handouts for participants to follow during discussion. In addition, diagrams of these maps can be drawn on flip chart paper, erasable board (or turned into overhead transparencies) before the session and used to lead the discussion.

Some group leaders may prefer to write out or draw the maps during the group presentation. For example, in the HIV/AIDS handout, the letters **H - I - V** are written inside boxes (called “nodes”) and a line (called a “link”) is drawn down from each letter to another open box. Participants are asked if they know what each letter in **HIV** stands for, and the correct responses are written inside the empty boxes. Another line is then made from each word box (**Human, Immuno-deficiency, and Virus**) downward and another empty box is drawn. Participants are asked what each of the words means in connection to HIV, and correct responses are written in. The discussion is then summarized (*HIV is a virus that invades and destroys the cells of the human immune system.*) and questions are encouraged.

Maps prepared before group then used as discussion guides offer a more didactic and controlled type of discussion. Maps created during group create a more interactive atmosphere. Group leaders' style and the needs of the group should dictate which approach is used. Some leaders may find it useful to experiment with both approaches. For more information about Mapping, see Part 3 of this module (Mapping Worksheets) or visit the IBR Web site at <http://www.ibr.tcu.edu> and use the site's Search feature.

Risk Game Activity

For the **Risk Game** activity, two (2) containers, each containing 10 pieces of candy of a different color, are used in the demonstration. For example, one container with 10 red pieces and one with 10 blue pieces. Snack-sized sandwich bags are an inexpensive option to serve as containers. Jelly beans are good bets for the candy. Lifesaver Holes or TIC TAC Mints will also work. The main point is that participants should not be able to tell one color from the other by feel alone. All the candies should feel the same.

If participants are in a setting that allows them to do the homework activity, then each participant should be furnished with a “set” of candy bags to try with their friends.

HIV Update

Step 1

Begin with a brief introductory discussion including some of these key points:

It's fair to say that HIV infection and AIDS are like no other diseases we have ever had to deal with as human beings. They are very complex. That's why it's so important for people to have correct information about them.

To date, there have been about 900,000 AIDS cases in the United States. It's estimated that 45 million people worldwide are living with HIV/AIDS, and that in 2003 alone, over 5 million new cases were recorded. Worldwide, about 3 million people a year are dying from HIV-related illnesses and AIDS. In the U.S., over 1 out of every 3 cases is linked to injection drug use, either injection use itself (through shared needles) or being the sex partner of someone who injects (based on 2001-2002 figures).

Note: Update statistics as new data become available. Include statistics from your locality or community to help "bring the message home." The National AIDS Hotline at 1-800-342-AIDS or <http://www.cdc.gov/hiv/stats.htm> is a good source for updated statistics.

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

Ask participants and encourage a brief discussion.

Do you know anyone who has HIV infection or AIDS? (Or do you know of anyone who has HIV/AIDS?)

What feelings do you have when you think about AIDS?

Who do you know that you worry might be doing things that place them at high risk for HIV or other infections?

Transition:

We are living in a time when, in most any group of people, someone knows someone who has HIV. Or someone in the group is battling HIV themselves. It's a time when accurate information about HIV is vitally important. Let's spend a few minutes reviewing some of the basic information about HIV/AIDS so we are all clear about what all the terms mean and how HIV is most often spread.

HIV Update

Step 2

Distribute the *HIV/AIDS Information Map* handout (page 12). Or use diagrams on flip chart or erasable board as focus. Include the following key points in reviewing the meaning of HIV:

HIV is the name given to the virus that infects people then goes on to cause AIDS.

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

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

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

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

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

Refer to the AIDS portion of the *Information Map* and use it as a visual aid to briefly review the definition of AIDS. Include the following key points:

AIDS is the final stage of HIV infection. People are said to have AIDS when their immune system has become severely damaged and they are experiencing one or more of the serious illnesses which define AIDS.

HIV Update

The **A** stands for ACQUIRED. This means you can catch it from an infected person, and you can spread it if you are infected.

The **I** stands for IMMUNE. Again, this is the body's immune system. It's made up of different types of white blood cells that help fight disease.

The **D** stands for DEFICIENCY. Again, like the definition of HIV, deficiency means it's not working. It lacks the ability to function correctly.

The **S** stands for SYNDROME. This is a medical term used by doctors to describe certain symptoms or health problems that are related to a specific disease.

Most people who have AIDS probably carried HIV for many years before becoming ill. AIDS is defined medically as having HIV, plus one or more serious health problems such as certain types of pneumonia, cancers, infections, or forms of TB. Also, a person may be diagnosed as having AIDS when the virus has destroyed a large number of their immune system cells called CD4 cells or T cells. If a special lab test shows the person has a "CD count" of fewer than 200 CD4 cells, then the HIV infection has advanced into AIDS.

Step 3

Distribute the *HIV TIMELINE Map* (page 13), and use it to review the progress of HIV infection from exposure to AIDS. Include these key points:

Let's take a quick look at how most people become infected with HIV, and how things progress for them afterwards. For adults and teenagers today, the primary way they are exposed to HIV is through sharing injection "works" (such as needles, syringes, cookers, or cottons) with someone who has the virus, and/or through unprotected sex with someone who has the virus. The term "sex" includes man/woman sex with the penis inside the vagina (usually referred to as vaginal sex); sex where the penis is put inside the rectum/anus (referred to as anal/rectal sex); and oral sex, when either the man's penis or the woman's vagina is stimulated by the mouth or tongue of his/her sex partner (sometimes called "going down," "head," or "blow job").

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

HIV Update

After about 3 months, the immune system will produce something called antibodies in its attempt to fight off the virus. Unfortunately, HIV is so powerful the antibodies don't help. However, these antibodies can be detected by a blood test, called the HIV Antibody Test. This HIV test is widely available for free or low cost in most communities.

After the person is infected, it may take up to 10 years before he/she becomes seriously ill. It all depends on how healthy the person was to start with and how well they take care of themselves after exposure. **Even though the infected person feels fine, he or she can still spread the virus through unprotected sex or by sharing needles/works.**

At some point, the infected person will begin to experience symptoms. These early symptoms include fevers, night sweats, weight loss, fatigue, swollen glands, loss of appetite, and diarrhea. These symptoms used to be called ARC (AIDS Related Complex), but today they are referred to as HIV-related illnesses. This is the point at which most people finally see a doctor.

Anywhere from 6 months to 2 years after the first symptoms of HIV-related illnesses, most people will be diagnosed with AIDS, which is the late stage of HIV illness. By then, they may have developed cancers such as Kaposi's sarcoma (women may develop cervical cancer), lung infections such as Pneumocystis Carinii Pneumonia (PCP), brain disorders such as AIDS dementia, "wasting syndrome," (severe diarrhea and loss of appetite), TB, or uncontrollable outbreaks of herpes or Candida infection. They may also show evidence of a severely destroyed immune system with a CD4 cell count under 200. Many types of effective treatment are available for the different cancers and infections caused by HIV, but there is no cure for AIDS itself.

The time from onset of "full-blown" AIDS to death can't be known. Most people with AIDS may eventually die from the disease. However, a few people have had HIV for many years without going on to develop AIDS. It's very important for people who think they may have been exposed to HIV to have an HIV test. The sooner they know if they have HIV, the sooner they can begin following a health and treatment plan that may help prolong their lives.

Step 4

Distribute the *BODY FLUIDS Information Map* (page 14), and use it to review the ways by which HIV may be transmitted. Include the following key points:

HIV Update

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

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

Ask participants to help you list the ways HIV may be spread by infected blood. Clarify misinformation. Cover the following:

- Sharing injection needles, equipment, cookers, cotton
- Piercing, tattoos, "blood brother/sister" rituals
- Accidental cuts or sticks (for example, doctors, nurses, EMTs)
- Transfusions (clarify that HIV risk is very low nowadays)
- Hemophilia treatment (risk also very low nowadays)
- Blood from the childbirth process may expose a newborn infant

Summarize with the following key point:

The primary blood-to-blood transmission risk today is from shared drug injection equipment. The second most common is blood exposure to newborn infants during childbirth when the mother is infected with HIV. An infected mother has about a 30% chance of passing HIV to her unborn child, either during pregnancy or during childbirth.

Ask participants to help you list the ways HIV may be spread through infected semen or vaginal fluids. Cover the following:

The **semen** (cum) and **vaginal fluids** (juices) of HIV infected people also contain high concentrations of the virus.

Vaginal sex (penis in vagina). HIV in semen can penetrate the membranes that line the vagina. HIV in vaginal fluids can penetrate the thin, delicate skin of the penis and urinary opening at the tip of the penis.

Anal sex (penis in rectum). HIV in semen can penetrate the membranes that line the rectum. Small cuts or tears may allow HIV in semen to pass directly into the bloodstream.

Oral sex (mouth on penis or vagina). HIV in semen or vaginal fluids can penetrate the mouth's membranes. Small cuts or sores in the mouth allow HIV in semen or vaginal fluid to pass directly into the bloodstream. If the person performing oral sex has mouth

HIV Update

sores, bleeding gums, or crack pipe burns, etc., then there may be blood in his/her mouth. If they have HIV, they could spread it via blood while performing oral sex.

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

The **saliva** (spit) of an infected person does not have enough HIV to worry about. HIV cannot be spread through contact with saliva. However, if there is blood mixed with the saliva, then there's a potential problem. In this case, the transmission risk is from the blood, not the saliva. Blood may be in saliva from gum disease, mouth sores or cuts, crack pipe burns, etc.

The **tears, sweat, urine, or feces** of an infected person do not contain enough HIV to worry about. Therefore, HIV cannot be spread through contact with these body fluids.

Summarize the discussion by reviewing the ways HIV can and cannot be transmitted. Include the following key points:

HIV can be transmitted by an infected person via blood contact (especially shared drug injection equipment), and by contact with sex fluids during vaginal, anal, and oral sex. The breast milk of an infected mother may also expose her infant if she breast feeds. Pregnant women can reduce HIV risks for their new born infants by taking antiviral medications during pregnancy. Studies have shown taking these medicines greatly reduce the chance that a mother will spread the virus to her unborn child.

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

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

Transition:

Prompt participants to ask questions by asking some of the following:

What have I failed to cover that you still have a question about?

How does this information differ from what you already know about HIV/AIDS?

What concerns you most about HIV/AIDS?

Step 5

Read the following brief “cases” to participants, and ask them to tell you the level of risk for the characters involved, based only on the information contained in the “case.” (Discourage speculations about “if.”)

Ask participants to base their assessments only on the “facts” presented in the case studies. The unknown is a key factor in assessing HIV risk and this is the main point you’ll be trying to stress.

Case # 1

John and Mary have been married for 20 years and are sexually faithful to each other. John is in recovery; however, he continues to shoot a few speedballs with his buddies on the weekends and smokes a little dope. Since he doesn’t use that often, he doesn’t have any equipment, so he always borrows someone else’s.

Ask the following questions and make note of participants’ responses on flip chart paper or an erasable board:

Who’s at risk for possible HIV infection in this case?

On a scale of 1 to 10, how big is each person’s risk?

Case # 2

Joe shoots about 3 times a day and smokes crack, too. He avoids sharing his works most of the time, but not always. Joe is single and often pays for sex, either with money or drugs. He prefers to receive oral sex, but never uses a condom. Many of the women who perform oral sex on him are heavy crack users.

Follow the above procedure for listing participants’ answers:

Who’s at risk for possible HIV infection in this case?

On a scale of 1 to 10, how big is each person's risk?

Conclude with the following questions:

How did you make your judgments of HIV risk for these characters?

What would have made it easier for you to judge the risks?

We talked about these people’s risks on a 1 to 10 scale. What could each person do to reduce their risk by a few points on this scale?

Step 6

Introduce the *Risk Game*. Show participants 2 containers of identically shaped candies of 2 different colors. Explain that there are 10 candies in each container. Read over the following script to get an idea of how to lead this activity.

The **red** candies in this container are just that—candies. The **blue** candies in this container, however, are a lethal poison. The poison doesn't kill you instantly, but rather causes a slow and painful illness that can go on for years before it actually kills you. The suffering, loss of ability, and pain are indescribable. There is no antidote. Got it?

Now, if I offered you a **red** candy from this bag, would you worry very much about eating it?

Okay, how about if I took one **red** candy from this bag and replaced it with a **blue** one (*demonstrate this step*)? Now I have 9 “safe” candies in the bag, and one “dangerous” one. How many of you would be willing to close your eyes, reach into the bag, select a candy, then pop it into your mouth and eat it without looking?

Stop here and process participants' thoughts and feelings about risk-taking.

Okay, let's say I replaced 2 “safe” candies with 2 “dangerous” ones (*do it*). Now how many would be willing to reach in, take one, and swallow without looking?

Again, stop and discuss people's thoughts and feelings. Continue the pattern of replacing “safe” for “dangerous” candies until the mix/ratio is such that participants are no longer want to take a risk.

Process the activity with the following questions:

What kind of feelings did you experience during this exercise?

What did you learn about yourself and your willingness to take risks?

What was the deciding factor for you to stop taking a risk?

HIV Update

Provide closure for the exercise using some of the following key points:

The purpose of this exercise is to help you get in touch with how each person judges risk. We all are different in terms of how much risk we are willing to take.

The unknown is a big factor when it comes to HIV risk. Sharing needles/works or having unprotected sex is very much like reaching into the candy bag with our eyes closed. We don't know if we're going to get a red candy or a blue one. If we don't know another person's HIV status or habits for certain, then there's an HIV risk if we have sex or share needles with that person.

Next week, we'll talk about how we can improve our odds through personal risk reduction. HIV is preventable, and it is possible to dramatically lower the odds in favor of not getting or passing on the infection.

Step 7

Tell participants that you'd like them to take part in a "homework" type experiment before the next session. Explain these guidelines:

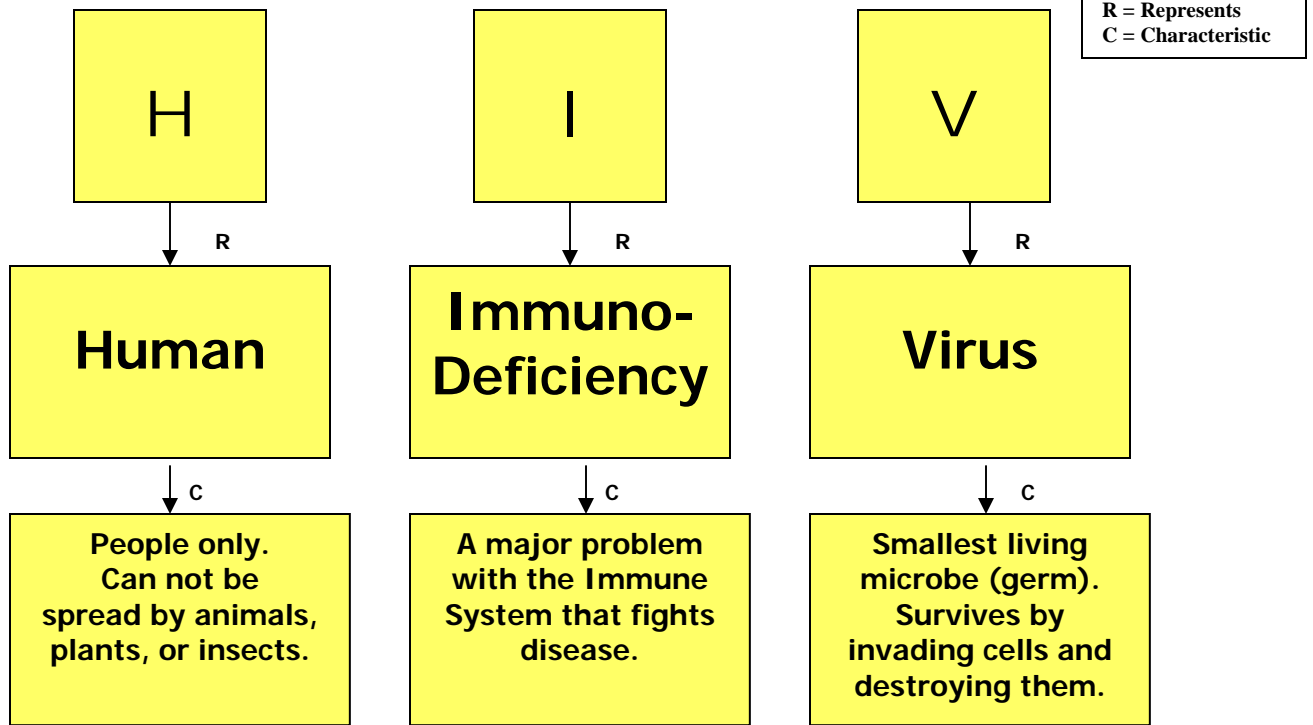
Give each person a set of candy bags (one bag of "safe" candy and one bag of "dangerous" candy.)

Ask participants to use their candy bags to demonstrate the *Risk Game* to one or two of their friends or family members during the coming week. Give the following suggestions:

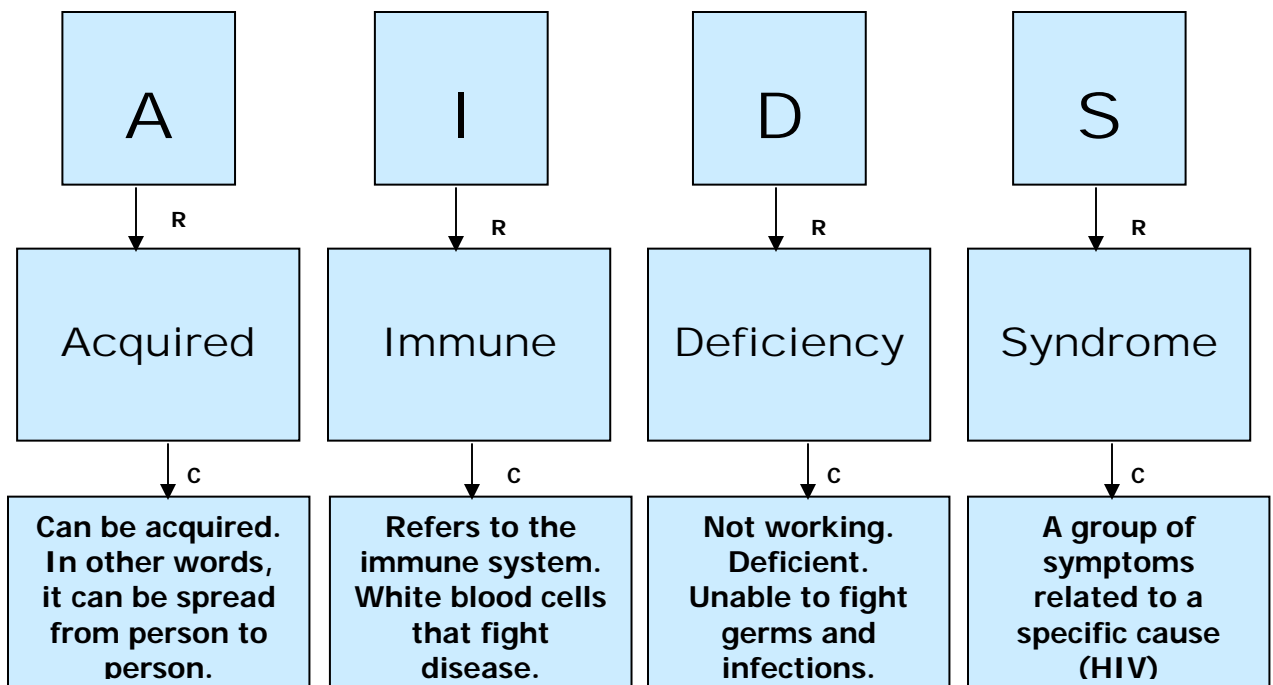
Explain the "risk game" to your friend or family member just the way we did it in group today. See if you can predict who will take the biggest risk and who won't.

Observe how your friends react to the game. Notice how much risk different folks are willing or not willing to take. If they seem interested, tell your friends or family members a little about how this game applies to HIV risk (or other health risks that people take.) Observe their reactions. We'll talk about the results of the experiment during our next session.

HIV Update

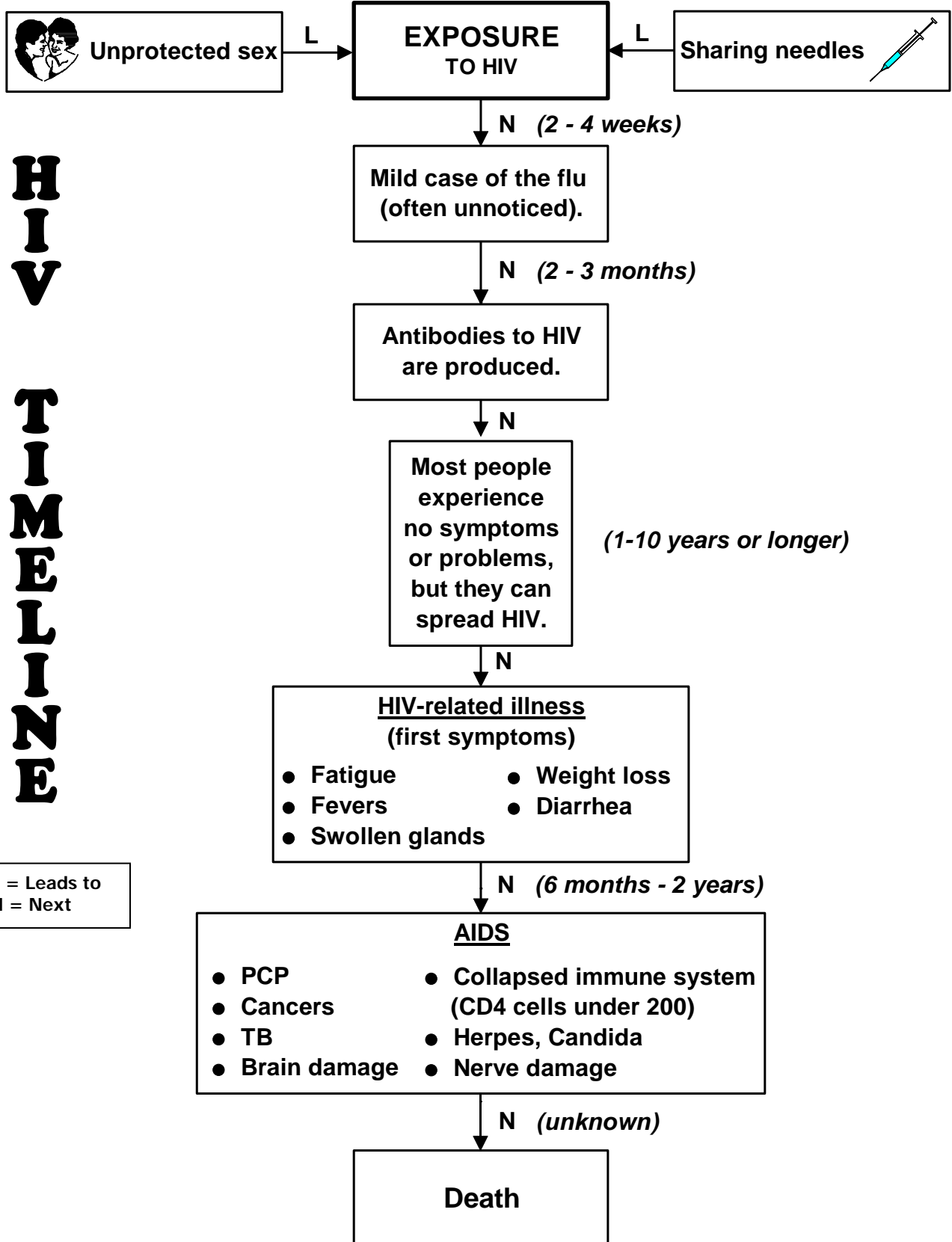


HIV is a human virus that invades and destroys the cells of the immune system.



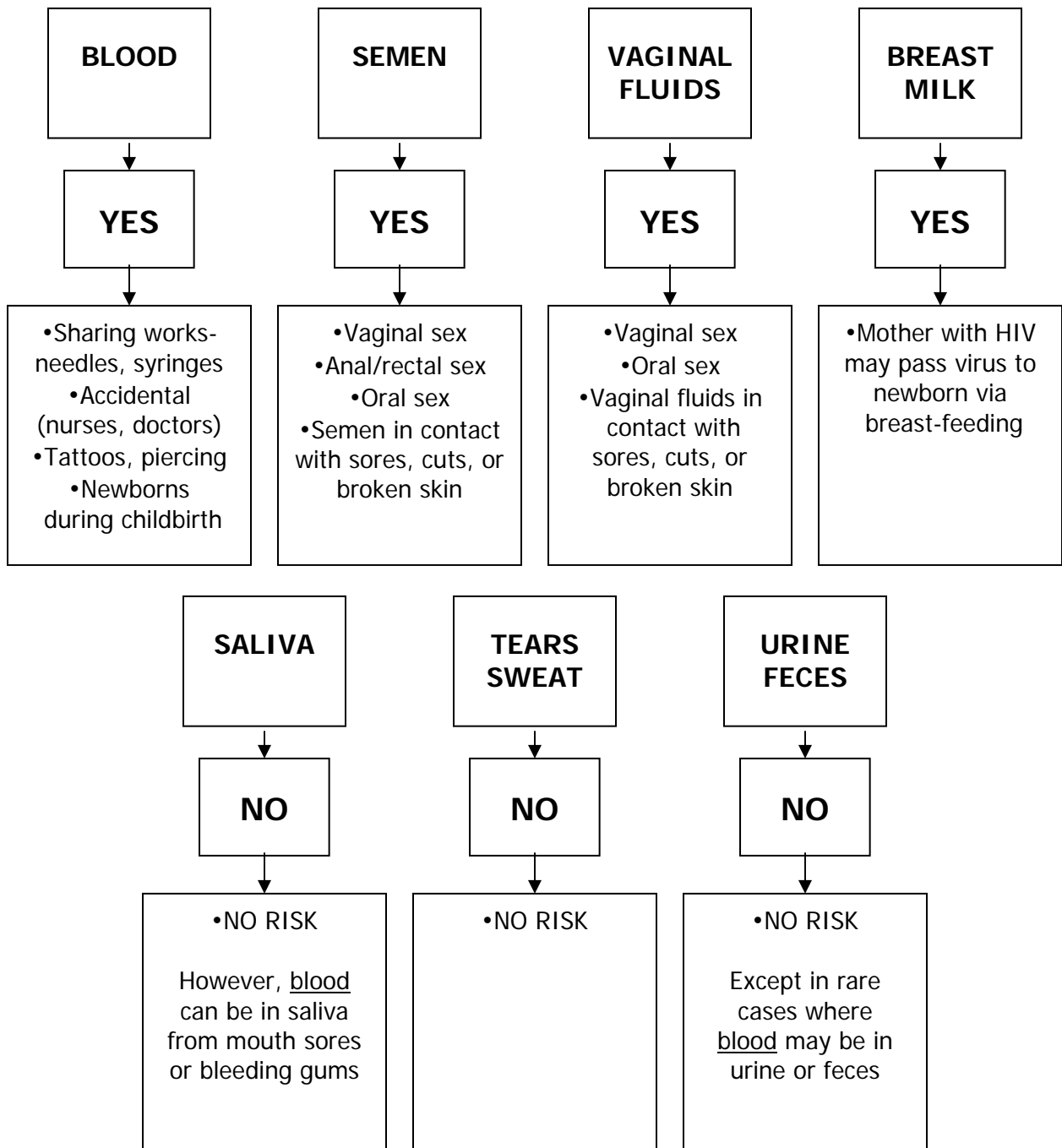
AIDS is the late stage of HIV infection, resulting in illnesses and cancers the body can no longer fight off.

HIV Update



HIV Update

HIV PRESENT IN BODY FLUIDS? Yes / No



Part 2:

Acting To Protect Your Health

Acting to Protect Your Health is part of the *Approaches to HIV/AIDS Education in Drug Treatment* manual developed at TCU. This session features a leader's script, with notes, worksheets, and handouts for addressing social anxiety and assertiveness as important issues in communicating about safer sex. Participants are invited to explore their own feelings and communication style when it comes to discussing prevention issues with a partner. Time is allowed for role play to practice new skills.

Source: TCU / Institute of Behavioral Research. From treatment manual *Approaches to HIV/AIDS Education in Drug Treatment*

Acting to Protect Your Health

Step 1

Introduce the concept of all people having a personal right to avoid health risks, especially HIV risks. Include the following key points:

We all have the right to refuse to put our health at risk, and to tell others in no uncertain terms about our decision not to take a health risk. This means that no one has the right to force, coerce, trick, or manipulate us into taking a health risk.

Health protection is a personal right. Acceptance of your right to watch out for your own best interest is the foundation of health-related assertiveness. We want to encourage you to develop an “I’m worth it and I can do it” attitude about reducing your risk for HIV and other serious infections, such as hepatitis, gonorrhea, herpes, etc.

The flip side is that we don’t have the right to push, force, coerce, trick, or manipulate other people into risking their health, either. If someone wants to use a condom when they have sex with us or if they refuse to share injection equipment with us, we should respect their right to protect their health. Don’t take it personally—just accept that it is the other person’s right.

Here are some rights that can influence health protection. Remember, if you have rights, then other people are entitled to those same rights, too.

Write the following on flip chart or erasable board and discuss:

We have the right to be treated with respect.

We have the right to say “no” and to have our “no” respected.

We have the right to express our feelings, needs, and decisions.

We have the right to protect ourselves (and our families) from HIV.

Lead a brief discussion to explore how these rights can play an important part in helping us avoid HIV-risks.

Do you agree with these rights?

How will accepting these rights help you make better health decisions?

Which of these rights is the most important for you?

How can we make sure we respect the rights of others?

Acting to Protect Your Health

Conclude the discussion with the following key points:

Your right to protect your health is an important issue, but there are other issues as well. After you make your decision to stop taking HIV risks, you have to find ways to stick to it. For most of us, this is where it gets tough. Everyone in this room would agree with the statement “I don’t want to get HIV” or “I don’t want to give HIV to anyone.” So how can we stay on top of it?

We’ll spend the rest of the class on this issue. Be thinking honestly about the kind of **real life** situations that make it tough to always avoid HIV risks. I’ll ask you to share some of those later. First, though, let’s talk about how assertive communication can help.

Step 2

Introduce the topic of communication styles by asking participants what “assertiveness” means to them. List characteristics they describe on flip chart or erasable board. For example:

When I say that someone is assertive, what kind of person do you picture?

Distribute *ASSERTIVENESS Information Map* handouts (page 23). Use the map to briefly define assertiveness and review the components of assertive communication. Cover the following key points:

Assertive communication is an up front way of expressing or telling others about your thoughts, feelings, decisions, or rights. When we communicate assertively, we use a tone that is firm, but respectful of others. We avoid put-downs, insults, and any “game-playing.” We tell it like it is—with respect for ourselves and for others.

Aggressive communication, on the other hand, is confrontational and disrespectful of others. It’s often loud, angry, and full of put-downs and insults. The result is that the person we’re talking with may become angry and tune us out. When this happens, we lose because we’ve lost the chance to get our point across and persuade the other person to cooperate with us.

Passive communication sends the message that you’re a push-over and easy to manipulate. It’s often timid, hesitant, and wishy-washy. The result is

Acting to Protect Your Health

that others may think they can tell you what to do or talk you into something you don't want to do. Sometimes we're passive because we want to be friendly and get along. But when it comes to protecting our health and defending our rights, passive doesn't cut it.

Continue the discussion by inviting participants to consider the following factors in effective assertive communication:

Most of us don't communicate assertively all of the time, and that's okay. But when we have an important point to get across—like when we want to stick by a decision—then assertiveness will work best. Let's look at some tips for communicating assertively, especially when avoiding HIV and other health risks is the issue.

First, know your **goal**. Remember, assertive communication helps get across that we are serious about what we're saying, and that we are firm in our decision. Your goal in communication becomes your "bottom line." In other words, it is an issue around which you do not intend to compromise.

Tone of voice is an important part of assertiveness. We want to use a tone that is calm, self-assured, up-front, sincere, and firm. It's best to go with a neutral, matter-of-fact attitude—straight-forward. We want to avoid yelling, threatening, being sarcastic, whining, pleading, or manipulating. Keep anger out of your voice. Just speak your mind, and remember you have the right to do so.

Use I-language to get your points across. This involves speaking for yourself. "I-language" tells the other person where you are coming from in an honest, no-nonsense way. For example, "I'm not sleeping with you without using a condom," or "I'm worried about all this HIV business, man, so I'm not going to lend you my rig."

Listen, and don't get angry when people come back at you after you've communicated assertively. It's bound to happen from time to time. Listen politely—you already know your goal and you know you're not going to get side-tracked. Don't let the other person pull you into his/her trap by making you angry. Other people have the right to try and change your mind, but you have the right to stick by your guns and stay in control.

Reassert yourself when you need to, calmly and without anger. Tell the person again what you have decided is best for you. For example, "Hey, I know you don't like my decision, man, but it's my decision—no condom, no sex—that's the way it is." You may have to listen calmly and reassert yourself several times—that's okay. Eventually the other person should get the idea. Again, the key is to stay calm, don't get angry, and keep on asserting what you're going to do to protect yourself.

Acting to Protect Your Health

Conclude the discussion. Summarize with the following points:

Obviously, getting good at assertiveness takes practice. Especially the ability to listen to other people's attempts to change your mind without getting angry or led off the subject. It's worth the effort to practice, though, because it helps increase your self-confidence and your self-respect.

Next, we'll practice being assertive in real life situations where HIV risk is an issue. Take a minute to think about situations you have come across or thought about where standing up for yourself about health protection could be an issue.

Step 3

Lead the group in practicing assertiveness by introducing role play scenarios (see page 24) that focus on safer sex and other health-related issues.

Facilitator Notes:

The role play material (topics, situations, difficulties) should be generated by the group, if possible. Ask for about 3 or 4 situations, as time allows. Sample scenarios are included at the end of this session.

Role play exercises allow people to rehearse behavior and receive feedback and encouragement from others in a "safe" environment. This can improve their confidence and resolve to adopt new behaviors or communication styles. The biggest challenge in leading role plays is to keep participants focused on the new behavior being practiced (in this case assertiveness) instead of on the content of the role play itself.

Don't feel shy about stopping role players and re-focusing them on the goal of practicing assertive responses to potential HIV risks. By all means, interrupt the role play if it starts drifting off into left field or "he said/she said" debates.

Consider using a "two-statements, two-responses" technique. This type of role play helps keep the group focused and on track. The following instructions will provide you with a general idea of how to use this technique.

Acting to Protect Your Health

After the group has generated a list of situations they label as difficult, in terms of being able to effectively practice HIV risk reduction, ask for volunteers to role play. It's generally unwise to force people to serve as role players. Allow people to volunteer. Remember that some people will learn more from observing and giving feedback than they will from role playing themselves.

Set up two chairs facing each other at the front of the room. Have the role players sit in these chairs. For each situation/scenario, ask the group to help identify the “core” issue involved. Then have one role player deliver a “risk invitation” statement to which the second role player will respond assertively. Here’s an example:

Scenario: A woman has decided she wants her boyfriend to use condoms cause she’s sure he’s back on the needle again. She really loves him. Every time she brings up the condom thing, he begs and sweet talks her until she finally gives in and does it without a condom.

Leader asks: What’s the issue here? Why would this be a tough situation for staying on track with your goal to avoid HIV?

Leader continues: Okay, sounds like the central issue is that the woman needs to stand by her decision in the face of some “emotional” manipulation. She wants to say “yes” to love, but “BIG NO” to HIV.

Leader continues: Let’s try a few lines and practice an assertive response. Role player #1 will be the boyfriend, and role player #2 the woman. Role player # 1, I want you to lay your best sweet talk lines on her. Role player #2, I want you to remember your goal and practice the assert/reassert technique we talked about earlier. Begin when you’re ready.

Player #1: Oh, baby...you’re so good. You turn me on so much. Please don’t say we gotta use a rubber.

Player #2: I want to start using condoms. I don’t feel easy with the fact that you’ve started shooting dope again. I’ve made up my mind, and it’s the right thing for me.

Player #1: Baby, you’re breaking my heart with that condom business. Come on, don’t I always treat you really good?

Acting to Protect Your Health

Player #2: You are good, baby. Yes you are. And I know you'll be good with a condom, too. That's what I need from you—we gotta use a condom or forget it.

Leader breaks in: Okay. Stop right there for a minute. That was really good. Player # 1—you sure know how to lay on the sweet talk, brother. Well done and very believable. And Player # 2, you really sounded up front and firm. How did this feel to you?

At this point, stop the action and process what was going on for the role players.

Ask Role Player # 2 (the “asserter”):

- How did it feel to respond assertively?**
- What kind of thoughts were you having?**
- How confident did you feel?**
- How will this approach work for you in real life?**

Ask Role Player # 1 (the “assistant”):

- How did you react to her assertive response?**
- How did you feel about it?**
- What kind of thoughts did you have?**
- If this had been real life, how would you have reacted?**

Ask the group for constructive feedback to help the “asserter” improve her/his technique.

- What suggestions do you have for the asserting player?**
- What would help make the response even stronger and more up front?**

After discussing the feedback from the group, you may want to suggest that the role players to do a “Take-2.” If the role player who is playing the “asserter” role is having a particularly difficult time, you may want to do several “takes” until he or she feels comfortable and confident about his/her ability to deliver an assertive response.

After the subsequent “takes,” ascertain how the “asserter” is feeling. Is his/her comfort level improving? What improvements do the assistant and the group observe?

Acting to Protect Your Health

Here are the key points for facilitators to keep in mind:

Develop role play material that focuses on both sexual and injection HIV risk situations/scenarios. Have the group provide situations, or invent your own. Do one scenario at a time.

Have the group help you identify the core issue—this will define the “asserter” role player’s goal.

Ask for volunteers to play the “asserter” and the “assistant” roles. Try the “two statements, two responses” technique. In some cases, you may want to stretch it to “three and three.”

Stop for processing, and praise the role players. Get feedback from the “asserter” first, as discussed above. Next, process the experience for the “assistant” role.

Ask the group for constructive feedback. Ask for helpful suggestions for the “asserter.” This is an especially important step because it asks the group to share the thoughts and feelings they experienced while witnessing the role play.

Try at least one more “take” per scenario after the “asserter” has processed the experience and received feedback. After the take, ask the “asserter” to decide if his/her comfort, confidence, and technique is improving.

Praise their efforts, thank role players, have the group give them a quick round of applause.

Move on to the next situation/scenario and recruit new volunteers.

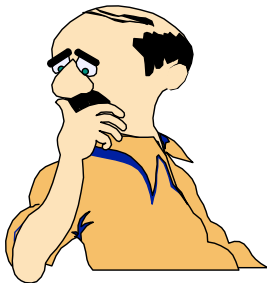
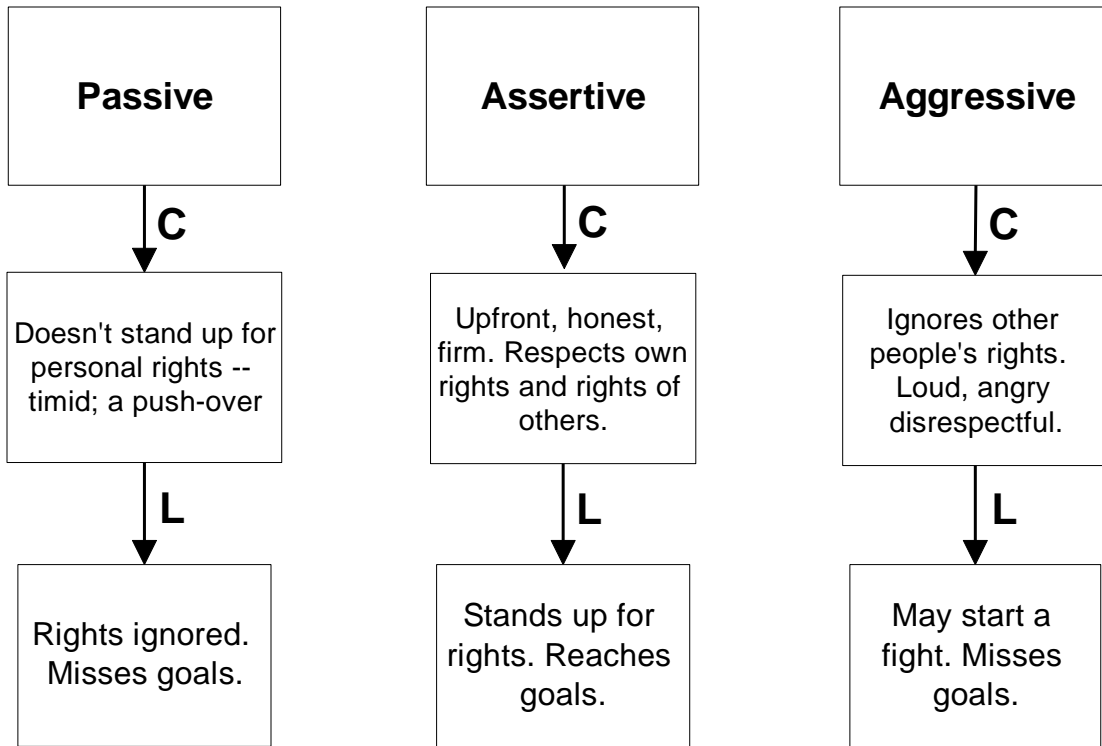
Provide closure for the role play activities using some of the following key points:

Assertiveness is one way we can put our right to protect ourselves against HIV into action. It’s not always going to work perfectly, but it does give us an edge in difficult situations. A key skill is learning to assert and reassert our needs, goals, and intentions without becoming angry. It takes time and practice to get good at it.

We can use assertive techniques in other situations as well. There are many areas of life where we need to stand up for our rights. If you’d like more information, talk to me after group, and I can give you the names of some books you might find helpful for learning more about the assertive way.

Acting to Protect Your Health

ASSERTIVENESS



- | Assertive Tips |
|--|
| <ul style="list-style-type: none">● Be firm about your goal/decision● Strong, level tone of voice● Use I-statements● Listen (without anger)● Assert yourself again (without anger) |

LEGEND
C = Characteristic
L = Leads to

Sample Role Play Scenarios

Case #1

Ted has been in recovery for awhile. However, after a fight with his girlfriend, he experiences a set back. He decides to throw in some money with some friends and make a score. After the drugs are divided, someone hands Ted a used rig to use.

How should Ted handle this to avoid HIV exposure?

Players: Ted and two friends who try to convince him to use the dirty rig.

Case # 2

Mary and John have been together for several months, and have never used condoms. Mary becomes concerned that John hasn't been completely honest about how many girlfriends he has. She decides to request that they begin using condoms.

How can Mary assert her rights?

Players: Mary and John, who becomes defensive at the request

Case # 3

Larry goes on a blind date with Sherri, and things get "hot" fairly quickly. Larry has heard that Sherri sleeps around and that she has been known to shoot heroin if it's around. As the moment gets more romantic, Larry pulls out a condom. Then he sees the look on Sherri's face.

How can Larry stand by his right to use a condom?

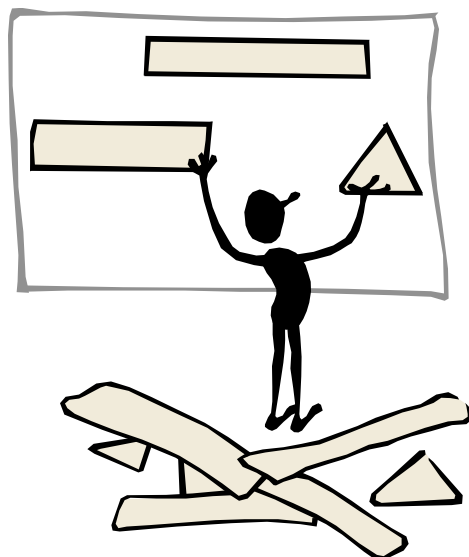
Players: Larry and Sherri, who cops an attitude and "feels insulted"

Part 3: Mapping Worksheets

These **Mapping Worksheets** were adapted from the manual *TCU Guide Maps: A Resource for Counselors* and feature a specific focus on HIV, AIDS, communication, and risk reduction. Each mapping worksheet follows a “fill in the blank” format to encourage participants to consider various cognitive aspects dealing with safer sex issues. Once participants complete their worksheet, group discussions and commentary on the HIV issues and interpersonal strategies are facilitated.

Source: TCU / Institute of Behavioral Research. Adapted from treatment manual *TCU Guide Maps: A Resource for Counselors*

Mapping Worksheets



Why a “map”?

The purpose of this section is to introduce a promising technique that can be used by counselors to help clients represent and resolve personal issues. There is research that validates the effectiveness of this tool in the counseling process, so we give you some background and a quick look at the major research findings on maps.

Types of Maps. *Node-link maps* are tools that can visually portray ideas, feelings, facts, and experiences. There are three broad categories of these maps:

- Free or process maps**
- Information maps**
- Guide maps** (the focus of this section).

As you can see from the examples, the **nodes** in a map are drawn as enclosed boxes and represent thoughts, actions, or feelings. The map **links** are simple lines with arrows that are labeled to show the direction of influence and the interrelationships among the nodes.

Free or process maps: Using a chalkboard, flip chart, paper and pencil, or computer, client(s) and counselor can work together to create a map of the problem or issue under discussion. For examples of the use of free mapping, see *Mapping New Roads to Recovery: Cognitive Enhancements to Counseling*, Dansereau, Dees, Chatham, Boatler, and Simpson, 1993. Available at www.ibr.tcu.edu.

Information maps: They have been used in academic settings where research has showed them to be powerful study tools. These maps organize facts in a specific content area and present them in an easy-to-remember format. The first research on mapping was done with college students, who could remember more main ideas from maps than from comparable texts.

Mapping Worksheets

Guide maps: These are pre-structured templates with a “fill-in-the-space” format that guides the client’s thinking within a specific framework (e.g., personal strengths, goals), and allows ample freedom for self-expression. In a group setting, a guide map can be used to focus and keep a discussion on track. As an individual activity, it provides a structure for thinking about and organizing to otherwise nebulous personal issues. In group work, the map can provide some assurance that each group member has had a chance to visit a particular issue personally, even if there has been insufficient session time for each of them to air those issues within the group.

Roots and Rationale. Node-link maps have an empirical base in research dealing with the effects of using two dimensional visual representations. These graphic representations are frequently found to be more effective than verbal discourse or written narrative in dealing with complex problems and issues. Flowcharts, organizational charts, Venn diagrams, pictures, and graphs can increase communication efficiency by making related ideas easier to locate and recognize, and, as a result, potentially more amenable to inferences and recall. The physical formats of spoken language or written narrative are linear “strings” of ideas. Visual representations, on the other hand, have the capability of simultaneously clustering interrelated components to show complex multiple relationships such as parallel lines of thought and feedback loops.

Problem-Solving: Personal problems may be complex, making them both difficult to analyze and emotionally daunting to resolve. A visual representation such as a node-link map can capture the most important aspects of a personal issue and make alternatives more salient for both the client and the counselor. Because this has the potential to make a problem appear more manageable and a solution more probable, it may diffuse at least some of the anxiety surrounding the issue, as well as increase motivation to work toward a solution.

Evidence-Base: In 1989, maps were first studied as personal management tools for college students in substance abuse prevention research (Tools for Improving Drug and Alcohol Education and Prevention, D.F. Dansereau, Principal Investigator) sponsored by the National Institute on Drug Abuse (NIDA). At the same time, through the NIDA-sponsored DATAR (Drug Abuse Treatment for AIDS Risk Reduction) project, (D. D. Simpson, Principal Investigator) maps were introduced to methadone maintenance clients and their counselors in three urban Texas programs. Findings from this research were quite positive. A second DATAR project (Improving Drug Abuse Treatment for AIDS-Risk Reduction) and the NIDA-sponsored CETOP project (Cognitive Enhancements for the Treatment of Probationers; D. F. Dansereau, PI) confirmed maps as useful counseling tools. The CETOP project did so with a particularly tough client pool, probationers in a criminal justice system treatment program. A summary of major findings from the four research projects follows, with referenced research articles that support each finding.



What Research Reveals About the Impact of Mapping: A Quick Summary



◆ **Memory for the Session:** Maps make treatment discussions more memorable.

- ◆ K. Knight, Simpson, & Dansereau, 1994
- ◆ Czuchry & Dansereau, 1998

◆ **Focus:** Maps increase on-task performance in group sessions and are especially helpful for clients who have attentional problems.

- ◆ Dansereau, Joe, & Simpson, 1993
- ◆ D. Knight, Dansereau, Joe, & Simpson, 1994
- ◆ Joe, Dansereau, & Simpson, 1994
- ◆ Dansereau, Dees, Greener, & Simpson, 1995
- ◆ Czuchry, Dansereau, Dees, & Simpson, 1995
- ◆ Dansereau, Joe, & Simpson, 1995
- ◆ Newbern, Dansereau, Czuchry, & Simpson, 2005

◆ **Communication:** Maps give clients greater confidence in their ability to communicate. This is especially so for non-Anglo clients and clients with limited education.

- ◆ Pitre, Dansereau, & Joe, 1996
- ◆ Dansereau, Joe, Dees, & Simpson, 1996
- ◆ Newbern, Dansereau, & Pitre, 1999

◆ **Ideas:** Maps facilitate the production of insights and ideas, stimulate greater depth, uncover issues, identify gaps in thinking:

- ◆ Dansereau, Dees, Greener, & Simpson, 1995
- ◆ Newbern, Dansereau, & Dees, 1997
- ◆ Pitre, Dansereau, & Simpson, 1997
- ◆ Dansereau, Joe, & Simpson, 1993
- ◆ Czuchry & Dansereau, 1999
- ◆ Dansereau, Joe, & Simpson, 1993

Mapping Worksheets



Quality of the Client & Counselor Relationship

◆ **Rapport**: Mapping facilitates the counselor-client therapeutic alliance.

- ◆ Dansereau, Joe, & Simpson, 1993
- ◆ Dansereau, Joe, & Simpson, 1996
- ◆ Dansereau, Joe, Dees, & Simpson, 1996
- ◆ Simpson, Joe, Rowan-Szal, & Greener, 1996

During Treatment Outcomes
(e.g., issue resolution & more effective life skills)



◆ **Positive Feelings Toward Self & Treatment**: Maps facilitate self-confidence, self-efficacy & problem solving. They can foster positive feelings about personal progress in treatment and positive perceptions of treatment process.

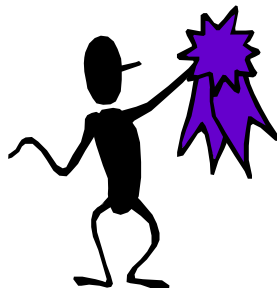
- ◆ Dansereau, Joe, & Simpson, 1993
- ◆ Dansereau, Joe, & Simpson, 1995
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- ◆ Pitre, Dees, Dansereau, & Simpson, 1997
- ◆ Czuchry, Dansereau, Dees, & Simpson, 1995
- ◆ D. Knight, Dansereau, Joe, & Simpson, 1994
- ◆ Pitre, Dansereau, Newbern & Simpson, 1997
- ◆ Blankenship, Dees, & Dansereau, in progress
- ◆ Newbern, Dansereau, & Pitre, 1999

◆ **Show Up "Clean"**: Clients who map miss fewer sessions and have fewer positive urinalysis tests for opiates or cocaine.

- ◆ Czuchry, Dansereau, Dees, & Simpson, 1995
- ◆ Dansereau, Joe, Dees, & Simpson, 1996
- ◆ Dansereau, Joe, & Simpson, 1993
- ◆ Joe, Dansereau, & Simpson, 1994
- ◆ Dansereau, Joe, & Simpson, 1995
- ◆ Dees, Dansereau, & Simpson, 1997

Mapping Worksheets

**After
Treatment
Outcomes**
(e.g., sober/clean,
no arrests)



◆ **“Clean” & Free: Clients who have mapped during treatment have fewer positive urinalysis tests for opiates, less needle use, and less criminal activity.**

- ◆ Pitre, Dansereau, & Joe, 1996
- ◆ Joe, Dansereau, Pitre, & Simpson, 1997

Adolescent Treatment: effects similar to adult findings

- ◆ Collier, Czuchry, Dansereau, & Pitre, 2001

“Mapping” as Intervention in Integrated Treatment Process Models

- ◆ Czuchry & Dansereau, 2003
- ◆ Simpson, Joe, Rowan-Szal, & Greener, 1997
- ◆ Simpson, 2004
- ◆ Simpson & Joe, 2004

Conceptual Overviews of Mapping Research

- ◆ Dansereau, Dees, & Simpson, 1994
- ◆ Dansereau, Dees, Bartholomew, & Simpson, 2002
- ◆ Dansereau & Dees, 2002
- ◆ Dansereau (in press – 2005)

Manuals for Counselors (at www.ibr.tcu.edu)

- ◆ Dansereau, Dees, Chatham, Boatler, & Simpson, 1993
- ◆ Dees & Dansereau, 2000
- ◆ Sia, Dansereau, & Dees, 2001
- ◆ Czuchry, Sia & Dansereau, 2002

Mapping Worksheets

Session Notes for Using Guide Maps

The Guide Map worksheets in this section can be used for during-group activities or as homework assignments for later group discussion. The following Guide Maps are included:

Suppose You Learned You Were Exposed to HIV? (page 32)

You Want to Start Using Condoms for Safer Sex (page 33)

Situation-Response: Partner Refuses to Use Condoms (page 34)

It is possible to build an entire group session around one map, or participants can be asked to complete and discuss several maps during the course of the group meeting. The general instructions for using the Guide Maps include:

1. Begin with a brief discussion and overview of the discussion topic. In the case of the Guide Maps in this module, participants would focus on the topic of HIV prevention. The group leader should provide information in the form of a brief mini-lecture or a review of information about condoms, HIV, and safer sex covered elsewhere in this module.
2. Distribute copies of a Guide Map to participants and ask them to complete it by filling in the blanks using their own ideas, feelings, experiences, and opinions to answer the questions in the boxes.
3. Once all participants have completed their maps, lead a discussion of the issues raised by the activity. The leader's job is to gently challenge and provide clarification, as needed. Leaders can choose to process the mapping activity as a large group, or participants can be divided into pairs or triads to discuss their maps before reporting back to the group as a whole.
4. Use open-ended questions to encourage discussion about the key issues raised by participants in completing their maps. Some ideas for general process questions include:

What did you learn about yourself as you completed this map activity?

What benefits and drawbacks did you identify for thinking about safer sex?

What benefits and drawbacks did you identify for being assertive about condoms?

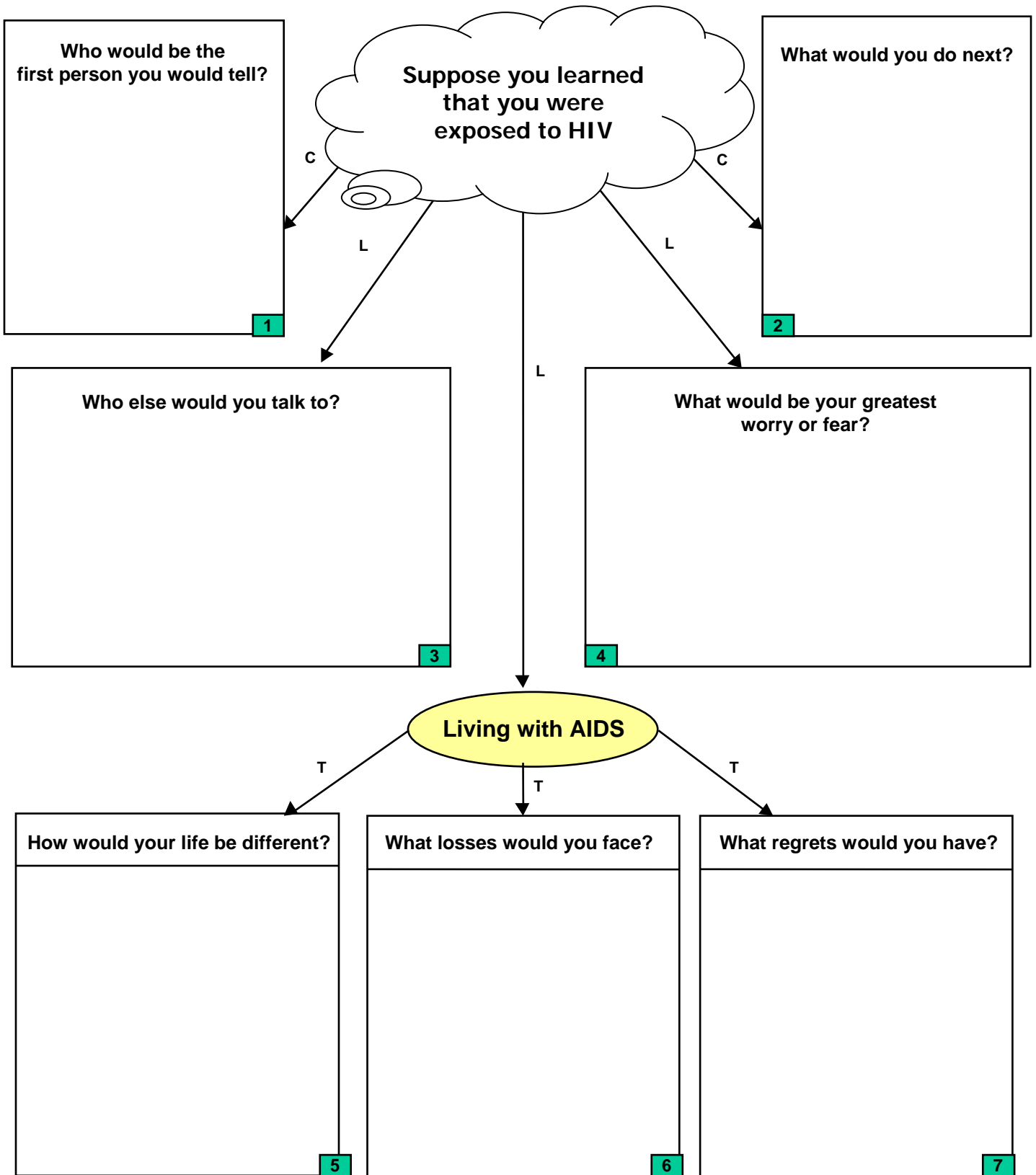
What benefits and drawbacks did you identify for passive behavior?

In what ways is it helpful to consider the other person's point of view?

What are some helpful ways you listed to respond to someone's refusal to use condoms?

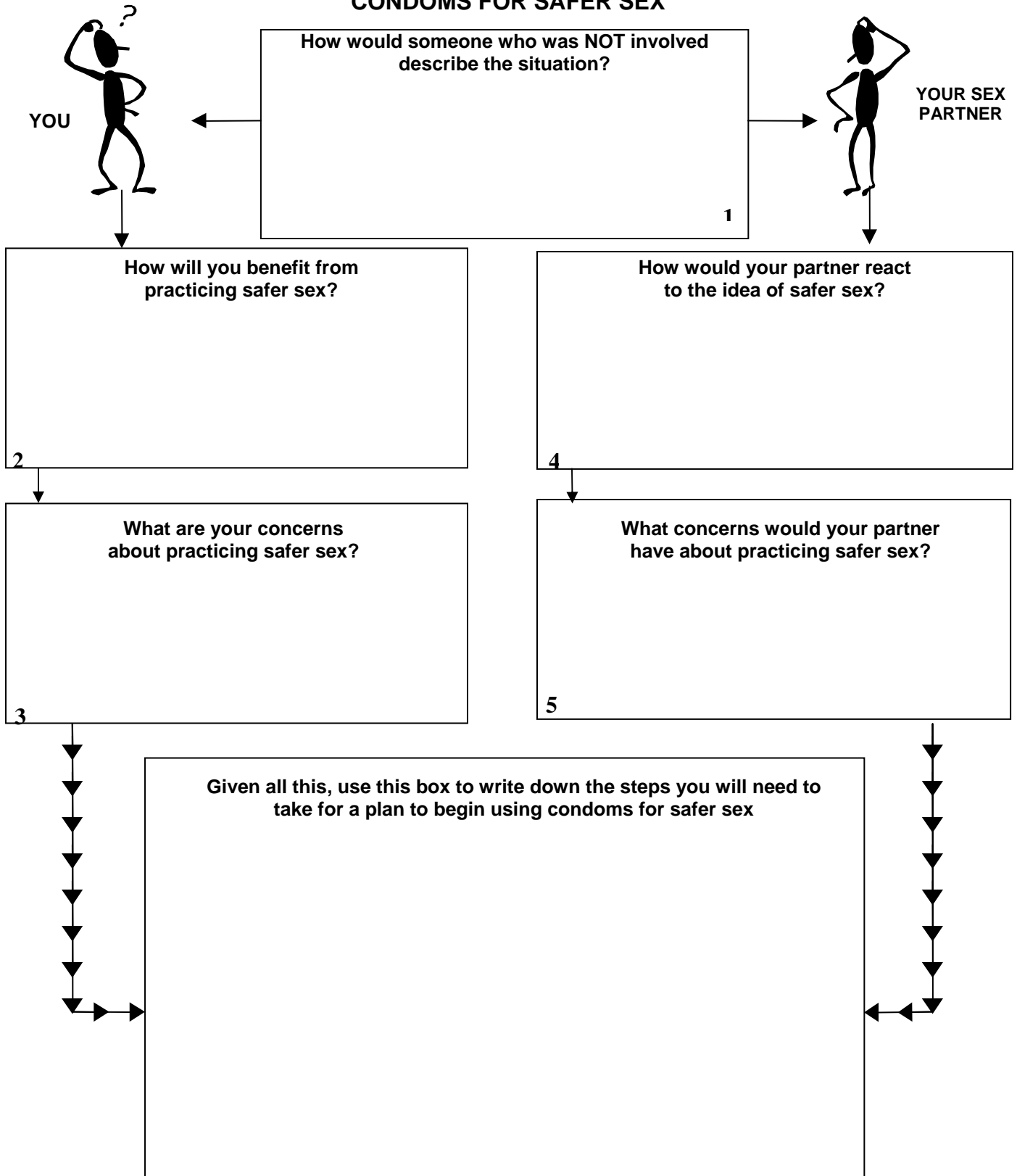
5. Encourage participants to share their mapping worksheets with family, friends, and members of their support network. When appropriate, offer blank copies of the worksheets for participants to complete and discuss with significant others.

Mapping Worksheets



Mapping Worksheets

YOU WANT TO START USING CONDOMS FOR SAFER SEX



Mapping Worksheets

Situation

You explain to a partner that you want to practice safer sex and use condoms. Even though you have stated your feelings and concerns, your partner still refuses and tries to talk you out of it.

1

RESPONSE

L = Leads to
T = Type

T

T

T

This would be a passive response:

This would be an aggressive or hostile response:

This would be an assertive response:

2

4

6



L



L



L

Possible consequences of a passive response:

Possible consequences of an aggressive or hostile response:

Possible consequences of an assertive response:

3

5

7

Mapping Worksheets

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HIV/AIDS Information Resources

Links of Interest

The public information office for the National Centers for Disease Control provides statistical information about HIV and AIDS in the United State, with Links to other AIDS-related sites:

<http://www.cdc.gov/hiv/stats.htm>

This site features Fact Sheets listed in an FAQ format for health and medical information about HIV and AIDS:

http://www.medicinenet.com/Human_Immunodeficiency_Virus_HIV_AIDS/article.htm

This health-oriented site offers HIV and AIDS information in 550 topic areas, including information for people living with HIV infection:

<http://www.thebody.com/index.shtml>

This government-sponsored site from the National Library of Medicine offers information about prevention, treatment, clinical trials, new HIV drugs, and more:

<http://www.sis.nlm.nih.gov/HIV/HIVMain.html>