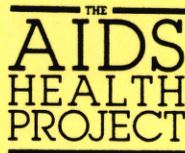


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STRESS MANAGEMENT LEADER'S GUIDE

***A FACILITATOR'S MANUAL FOR
STRESS MANAGEMENT FOR
PEOPLE AT RISK FOR AIDS***

Compiled by Marcia Quackenbush, M.S.
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University of California San Francisco

STRESS MANAGEMENT FOR PEOPLE AT RISK FOR AIDS

A Facilitator's Manual

Produced by the AIDS Health Project.

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ACKNOWLEDGEMENTS

Nearly the entire staff of the AIDS Health Project has assisted in the development and refinement of materials for the Stress Management Groups. The cooperative efforts of many people brought these materials into existence. Particular appreciations go to John Acevedo, M.S.W., Judy Macks, M.S.W., and William Vitello, Ph.D., for their willingness to share their experience and expertise in developing, facilitating and improving the groups sponsored by the AIDS Health Project.

I also want to express our thanks to the clients who were participants in our groups and who, by sharing their criticisms and compliments, have helped us continue to offer groups that are relevant and effective.

Stress Management for People at Risk for AIDS: A Facilitator's Manual is a publication of the AIDS Health Project. Individuals or organizations who purchase the manual also purchase the right to reproduce the group materials included in the chapter "Handouts for Group Members," for use in groups they organize or facilitate. No other written materials in this manual may be reproduced or distributed without written permission of the AIDS Health Project.

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DESCRIPTION OF CHAPTERS

*OVERVIEW

The history of the AIDS Health Project Stress Management Groups, how they have been used, who participates.

*GUIDELINES FOR GROUP LEADERS

General guidelines for leading successful groups, and some suggestions for guiding relaxation exercises.

*LECTURE NOTES AND GROUP MATERIALS - The weekly materials for the groups follow. They are arranged in the following order:

*GOALS, _SESSION_OUTLINES_AND_LECTURE_NOTES

Goals state the goals of each session.

Session Outlines lay out the materials to be covered each week and can be followed as a guide while leading each group session.

Lecture Notes clarify or elaborate on the session outline. The Session Outlines include reference numbers, which refer to the lecture notes.

LEADER'S INSTRUCTIONS FOR RELAXATION EXERCISES

Instructions to help leaders guide relaxation exercises. We suggest the first three relaxation exercises be handed out to group members in written form. These exercises are included in the "Handouts" chapter, rather than here.

*HANDOUTS

The written exercises, articles and relaxation techniques which you will hand out during or after the groups.

*BACKGROUND ARTICLES AND MATERIALS

Material to give you a better general background on the topics covered in group sessions.

*RESOURCES AND REFERENCES

For further information.

OVERVIEW

OVERVIEW

Stress Management Workshop

The AIDS Health Project is a program of the University of California at San Francisco. The project provides a variety of services, including educational support groups for people at risk for AIDS. We began in early 1984 and since then have worked with hundreds of people, most of them gay men.

We present this guide for others interested in leading Stress Management Workshops for people at risk for or concerned about AIDS.

Our rationale for offering the Stress Management Workshops is threefold:

1. We know that people faced with the necessity of making significant changes in their behavior will do so more effectively with peer support.
2. We believe that decreasing unnecessary stress and anxiety about AIDS will allow people to make clearer and better decisions based on necessary concerns for their health.
3. We suspect that stress might be a cofactor in contracting AIDS and hope that stress management skills might actually strengthen the immune responses of those at risk for the disease.

We are quite certain that our first two rationales have been met by our groups; we continue to hope that the third might play a part in AIDS prevention as well.

This group is designed as a structured, eight-week educational workshop. Each week there is a specific topic, and particular materials, concepts and skills are taught. Group discussion and personal interaction between members is an essential part of this structure. We have found that giving people a framework for their concerns about AIDS is one of the most effective ways to deal with the overwhelming feelings many experience.

These groups have been offered primarily for "worried well" gay men, since to date they represent the group at highest risk for AIDS in San Francisco. This perspective will be evident as you review the materials. However, we have also provided groups for people with AIDS and people with ARC, we have led co-sexual groups for men and women of all sexual orientations, we have had women-only groups, and we have worked with IV drug users. Our materials have also been used in a California AIDS project for persons with hemophilia and their sexual partners. Basically, this program can be adapted to the special needs of any group (of teenagers or adults) at risk for AIDS.

Please evaluate the materials, adapt them, use them, and share any feedback you have with us. We have found the groups to be effective and powerful tools in the battle against AIDS, and hope you find this to be true as well.

Who Should Lead Stress Management Workshops

Workshops are designed to be led by professionally trained, experienced group leaders. Leaders should have a suitable background in health psychology and be highly sensitive to issues related to people at risk for AIDS. Familiarity and comfort with the gay community is essential, as well as with the lifestyles and/or the communities of other groups at risk (e.g. IV drug users, heterosexual women who are involved with bisexual or gay men, etc.). Leaders should accept the basic theoretical assumptions of the workshops (see Background Articles and Materials: "Worried Well/ARC - Theoretical Assumptions,").

We believe the groups are most effective when they are co-facilitated by two qualified leaders.

Who Should Enroll in Stress Management Workshops

Clients of the AIDS Health Project are people who identify themselves as being at risk for or concerned about AIDS. They are offered a free, one-hour initial consultation. This is essentially an intake during which we get a sense of the client's needs, present the AHP program, and refer them to a group, if appropriate. We also provide medical and mental health referrals if these are requested.

Usual assessment issues apply here. We do not enroll clients in groups if they are frankly psychotic, addicted to drugs or alcohol, actively suicidal, or in some immediate crisis that demands individual attention. We do see people in recovery from substance abuse, many of our clients are also in individual therapy, and we have sometimes required clients to see an individual therapist or participate in a substance recovery program as a prerequisite to enrolling in a group.

We offer groups to anyone interested in enrolling who seems capable of making the necessary commitment, and who will be able to contribute to and benefit from the materials presented.

Fees

The AHP groups are offered on a low-fee, sliding scale basis. The fees are discussed during the intake interview, a fee is set, and a fee agreement is signed by the client. Fees are paid during the first or second group session. No one is refused services for inability to pay.

General Notes on the Group's Flexibility in the Structured Format

The materials presented here are structured, but the group format should not be seen as rigid. The AIDS picture is constantly changing and our clients have tended to be well-informed on current news about AIDS. We offer the same basic structure in all our groups, but adapt schedules and topics as necessary.

For example, before June 1985, when the AIDS antibody test was made generally available in June, 1985, there was tremendous controversy about how the government, the city, the gay community should handle antibody testing. This was addressed in our groups at that time. Once we knew the test sites would open, the bigger controversy was whether or not to take the test, how accurate the results were, how well confidentiality was safeguarded, etc. In some groups, we would do almost a full session on issues about the test. Later, when people in the groups began to come in with test results, the groups learned to deal with the crisis of someone having a seropositive test, the relief, and sometimes envy that was felt when someone had a seronegative result, and the difficulty of maintaining a resolve not to be tested or choosing against others' advice to do so.

With each new stage of experience about the antibody test, new materials needed to be brought into the group. Every new generation of groups comes with greater sophistication and knowledge. A skillful facilitator will integrate the current issues in a relevant fashion for each group. Staying up-to-date on AIDS research, events, controversies, is an essential part of preparation for the groups.

We note also that there is a tendency for the groups to require less didactic material as the weeks go by. This is reflected in our session outlines, which have less of this type of material in later sessions than earlier ones. We have deliberately erred on the side of overscheduling the time in the group for the purposes of this guide, but note that some editing of material may be necessary in a group that produces lively discussions simply because of time limitations.

How to Stay Up-To-Date

Keeping current with the medical literature on AIDS can be a full time job. Faster methods must be found! In San Francisco, local newspapers, both general and within the gay community, report much of the major news about AIDS (though accuracy is a concern). The New York Times reports regularly on medical, social, and political AIDS news. The New York Native reports on controversial AIDS issues. Focus, a monthly newsletter published by the AIDS Health Project, provides updates on AIDS research.

For further information, see the "Resources" section of this manual (p. 99).

Crisis In A Group

The AIDS Health Project groups are not therapy groups, but it is possible that over the course of an 8-week series some crisis might arise that demands

skillful therapeutic intervention. Most often these crises will be AIDS-related: a member receives a seropositive antibody test result; someone's lover or best friend is diagnosed or dies; one of the group members himself (herself) is diagnosed with AIDS.

Obviously, in instances like this, helping the group is the first priority. If an individual has experienced a personal crisis, some extra time may be given to help him or her cope. Returning to the structured format is an important sign to the group and the individual that the intense pain, fear or despair of AIDS can be contained appropriately. No one is served by being constantly overwhelmed by this epidemic.

A more demanding situation is the diagnosis of AIDS in a group member. This event will affect all the people in the group and each member should have some time to talk about their reactions. Once again, our greatest service, to ourselves as well as our clients, is to offer some containment for the sense of being overwhelmed by it all. Balancing the group structure with individual needs in a compassionate and thoughtful manner is one of the true challenges of this work.

GUIDELINES FOR GROUP LEADERS

Guidelines for Group Leaders: How to Make Groups Work

It would be impossible to outline everything needed to become an effective group leader. The following guidelines have been drawn from our experience running past workshops. Some of this material has been adapted from Group Leadership: A Manual for Group Leaders by Marilyn Bates and Clarence Johnson.

1. Leaders must provide a smooth interaction of didactic material, group discussion, and experiential exercises. This requires thorough knowledge of content areas, pacing/timing of tasks, and an appreciation of underlying group process. We have found that by adhering to a standard structure and format, members' anxiety about the uncertainties which they face are better managed. Open-ended discussions tend to get bogged down, which can lead to a "group sense" of hopelessness and helplessness. On the other hand, flexibility within the structure is needed to meet the unique needs of each group.
2. Leaders must take an active role in managing the workshops. This includes a clear introduction of sessions and tasks within the sessions, managing the flow of conversation, providing all participants an opportunity to take part, and ending the session in an orderly manner.
3. Leaders must provide a safe and respectful environment. Members must be assured that individual differences are respected and that their privacy will not be violated. There is a fine line between encouraging full participation and over-intrusion. The level of participation is greatly influenced by the level of trust established in the group. Leaders must understand the volitional aspect of trust-building. Group trust builds over time. The group leader needs to be sensitive to both individuals and the group as a whole, encouraging the unfolding and deepening of the level of communication.
4. In gay groups, leaders must set a tone that both acknowledges and validates a positive attitude toward gayness and permits the uncovering of suppressed internalized homophobia.
5. Leaders must model appropriate group behavior. Leaders need to participate in discussions and exercises led by co-leaders, being clear when they are providing information and when they are providing personal opinions.
6. Leaders need to ask for evaluative feedback at the midpoint and the end of the group.

Guiding Relaxation Exercises

Guiding groups in relaxation exercises is an endeavor which relies on skills, practice, and intuition. The best way to learn to guide exercises effectively is to work closely with someone already experienced in this area. In the absence of such a person, the following suggestions might be useful.

*Listen to a variety of people lead visualizations. Note the strengths and weaknesses of each presentation.

*Practice guiding your own exercises on tape. Listen to the tape carefully. Is it soothing and comfortable to listen to?

*Practice guiding exercises for friends or colleagues. Notice whether these people seem more relaxed after the exercise. Ask for feedback.

*There are many professionally-produced tapes for relaxation. Acquire and listen to a variety of these tapes.

Remember in guiding exercises to pace yourself so that there is ample time for instructions to be followed. Don't ever hurry through an exercise. Allow your voice to be relaxed and calm, speak slowly and clearly, and let your instructions flow naturally. It is your manner as much as any instruction you give that will communicate a quality of relaxation and comfort to your group.

Usually we hand out directions for the first three exercises covered in the groups. After this it is not usually necessary. Group members are able to remember subsequent techniques and rarely ask for handouts after the second week.

In Leader's Instructions for Relaxation Exercises, we include three standard techniques for inducing a state of deep relaxation.

SESSION OUTLINES & LECTURE NOTES

Week 1: Introductions.
Definitions of stress.
Stress and health.

GOALS:

1. Group members will all be introduced and begin to get to know one another and the facilitator(s).
2. General agreements will be met about ground rules and guidelines for group members.
3. Fees will be collected.
4. The group will learn the definition of stress and understand the implications of stress and stress management for health.
5. Group members will have an opportunity to discuss their personal experiences regarding stress and AIDS.
6. Two simple relaxation exercises will be learned ("One Full Breath" and "Progressive Muscle Relaxation").

STRESS MANAGEMENT GROUP - OUTLINE:

Week 1: Introductions.
Definition of Stress.
Stress and Health.

- I. Welcome.
Facilitators introduce selves briefly.
Participants introduce selves by name only.
Pass out and explain "Stress Scale".¹

II. Business.

Ground Rules²

On time.
Commitment to full eight weeks.
Call if late or absent.
No drugs or alcohol day of group.
No violence. *2: grp needs to be safe place -*
Confidentiality.⁵

Guidelines²

Participation encouraged, but not forced.
Trust increases with increased participation.
We will encourage communication between members.
We acknowledge individual differences.
We will maintain structure.
You get back what you put in.

Structure of groups³

Check-in.
Stress reduction exercise.
Presentation.
Discussion/written exercises.
Stress reduction exercise and closing.

Collect fees.⁴

III. Dyad introduction exercise.⁵ → *me*

IV. Program philosophy (briefly: the biopsychosocial model).⁶

V. Presentation.⁷

- A. Define stress ("A perceived imbalance between demands and resources available to meet those demands").

The important elements are perception, imbalance, demands,
resources.

- B. Three levels of stress:
1. Twentieth century -- "the stress of modern life."
 2. Gay.
 3. AIDS-related.

- C. A look at resources and demands:

	<u>Demands</u>	<u>Resources</u>
<u>Internal</u>	History Needs Expectations	Abilities (innate) Skills (learned) Attitudes
<u>External</u>	Environment Others' needs Others' expectations	Friends/Social Support Money "Equipment"/Environment

- D. Positive aspects of stress:
1. Excitement.
 2. Stimulus for change.
 3. Keeping you alive -- moving you out of the way of danger.
 4. Knowing you are alive -- "An organism without stress is a dead organism."
- E. Rewards of a good stress management program:
1. Better health.
 2. Better disposition.
 3. Knowing you are doing something positive for your health.

VI. Discussion:⁸ How are you experiencing your own balance of resources and demands, especially related to dealing with AIDS?

VII. Relaxation exercises.⁹

- A. Introduce concept.
- B. "One Full Breath."
- C. "Progressive Muscle Relaxation" (PMR).

VIII. Stress scale.¹⁰

IX. Handouts:¹¹

- A. Schedule.
- B. "One Full Breath."
- C. "PMR."
- D. Stress scale (exercise filled out and turned in again by group).

X. Goodbyes: Suggest people shake hands and exchange names with three others before leaving.

Week 1: Introductions.
Definitions of Stress.
Stress and Health.

LECTURE NOTES:

1. "Stress Scale" - See Handouts section. The "Stress Scale" is a form filled out by group members each week which will increase their awareness of and sensitivity to their levels of stress. Instructions are included on the form. Hand out the forms at the beginning of each group and collect again at the end.
2. Ground Rules and Guidelines - These are basic and common to most groups. For further background, see Background Articles: "Ground Rules" and "Guidelines for Group Members."
3. Structure of Groups - Most weeks will follow the general outline given here. Reviewing this will demonstrate to participants that these are structured groups and it will communicate to them your commitment to being organized and prepared for the groups.
4. Collect Fees - We provide an envelope for each group member for fee collection. Members put a check or money order into the envelope and return it to us. Those who have received a fee waiver for the group are asked to return an empty envelope. This way, the fee paid by each client remains confidential.

Postal Money Orders do not require the payor's name on them. We recommend that anyone who is uncomfortable writing a personal check for an AIDS organization purchase a money order and leave the "payor" section blank.

5. Dyad Introductions - In this exercise, people are asked to break into pairs and introduce themselves to one another. They can answer the questions, "Who are you?", "Why are you here?", and "What do you want from this group?" After 15 or 20 minutes, the group reassembles and partners introduce each other to the group.

In explaining this exercise to the group, point out that it is an exercise in listening as well as talking about oneself. Be sure to mention that if anything is said in the dyad that someone would like to remain confidential, he or she should let the partner know so it is not shared with the whole group.

6. Program Philosophy - The basic message in the "program philosophy" is that health is the product of many factors, including the presence or absence of disease-causing organisms, but also influenced by attitude, nutrition, exercise, social support networks, genetic dispositions and personal health history. For more background, see Background Articles: "Worried Well/ARC Program: Theoretical Assumptions." (p 91.)

7. Presentation - Follow the outline, encouraging input from group members relating these materials to their own experiences. We usually write the definition out on the board or large poster paper.

"Three levels of stress" - These are the three levels of stress we will focus on most in this group: (1) 20th century (crowds, noise, traffic, chemicals, etc); (2) Gay (being a member of a group experiencing social and legal discrimination); (3) AIDS-related (the special stresses which arise as a result of our experiences with AIDS).

"A look at resources and demands" - Write the diagram out on the board. This is just a general framework and not a definitive statement. It is presented as a way of helping people see the difference between internal and external demands. Generally, but by no means exclusively, one has greater control over internal resources/demands than external. Group members can add many more elements to the framework. ("History" can refer to health history, sexual history, personal habits, family backgrounds, cultural affiliations, past experience, etc; "Equipment" might include car or bus, stereo, musical instrument, gym, etc.)

8. Discussion - Much of Week 1 is highly structured. Try to allow the discussion to be somewhat looser and encourage (but do not force) participation from all members.
9. Relaxation exercises - Introduce the concept of exercises to decrease stress. There are generally three areas of focus for relaxation: the body (muscles, pulse rate, etc.), the breathing, and the mind. Most exercises are designed to affect one or more of these areas. In this group, people will have an opportunity to experience all three types of exercises. Other points to cover:

1. There are many different types of relaxation exercises.
2. Different types work best for different people.
3. We will teach several exercises in the group so people can find a type that works best for them.
4. They are more effective with practice - try to find time for some kind of exercise daily.

"One Full Breath" - See instructions in Handouts. This is one of the easiest relaxation techniques, and one which many people probably already do. In presenting the exercise, you might talk a bit about the power of breathing as a tool for relaxation (it is always available to work with; it is an elemental part of life-experience; people have studied breathing techniques for thousands of years; etc.)

Slowly guide the group through the exercise. Repeat two or three times.

"Progressive Muscle Relaxation" - See instructions in Handouts. This is a powerful and effective exercise which is easy to do. The PMR offers one the opportunity to compare

physiologic states of tension and relaxation. It can heighten awareness of muscle stress.

Guide the group through the exercise.

Discuss members' experience of the exercise when it is finished. Do people feel more relaxed? More tense? Did they like it? etc.

10. Stress scale - Have people fill out and return their stress scales.
11. Handouts - In addition to the instructions for the relaxation exercises, have a schedule of the group ready. See sample schedule in Background Articles: "Group Schedule".

Week 2: Increasing your awareness of stress.

The physiology of stress.

Early Warning Systems (Multidimensional Aspects of Stress).

Goals

1. Group members will become familiar with the concept of "check-in".
2. Group members will have a cognitive understanding of the physiological mechanisms of stress and how these can affect health.
3. Group members will be given a structure ("Multidimensional Aspects of Stress") to use in increasing their awareness of the presence and effects of stress in their daily lives.
4. A slightly more complicated relaxation exercise ("Breathing Meditation") will be learned.

STRESS MANAGEMENT GROUP - OUTLINE

Week 2: Increasing your awareness of stress.
The physiology of stress.
Early Warning Systems (Multidimensional Aspects of Stress).

- I. Welcome.
Stress scale.
- II. Check-in.¹
 - A. Describe check-in: A time to get your focus on the group, to let group members know how you're doing. Short -- a minute or two. Sometimes special topics, sometimes general.
 - B. This week's check-in: What stands out from last week's group?
- III. Relaxation:² Short PMR
- IV. Review.
 - A. Definition of stress.
 - B. Did anyone do the exercises last week? How was it?
- V. Physiology of stress.³

"Fight or flight" -- body's preparedness to meet or escape a stressor.

 - Pupils dilate (see better).
 - Hearing becomes more acute (hear better).
 - Muscles tense (fight better or run away faster).
 - Breathing becomes more rapid (more oxygen in blood).
 - Pulse quickens (blood moving more quickly, resources ready).
 - Blood moves to head - pounding head (more oxygen to brain, think more quickly).
 - Blood drains from extremities and moves to head and trunk - hands and feet grow cold and sweaty.
 - Body uses increased amounts of vitamins B & C.
 - Increased production of hydrochloric acid in stomach.
 - Occasional emptying of bowel or bladder ("scared shitless" -- lightens body, easier to fight or run).
- VI. Three stages of stress (from Hans Selye).⁴
 - A. Alarm - Aware of stressor, impulse for fight or flight.
 - B. Resistance - Resisting the impulse to flight or flee.
 - C. Exhaustion - Imbalance manifested in some dimension of stress.

(Selye examined physical illnesses which developed as a result of the exhaustion phase.)

- D. Stress-related illnesses which might manifest in the exhaustion phase include:
- High blood pressure (increased pulse rate).
 - Ulcers and other stomach problems (increased production of hydrochloric acid).
 - Susceptibility to common colds or flus (depletion of B & C vitamins).
 - Headaches, migraines (muscle tension, increased blood to brain).
 - Muscle tension (muscles tense).
 - Constipation (muscles tense).
 - Diarrhea or frequent urination (emptying of bowel or bladder).

VI. Early Warning Systems⁵ (Multidimensional Aspects of Stress).

- A. Thoughts.
Feelings.
Behavior.
Physiology.
Environment (including social support network).
Spirituality.

- B. Short description/definition of each of these.

VIII. Discussion:⁶ What's been stressful this week? How did you first become aware of it?

(Tie in discussion to materials presented, to whatever degree seems appropriate.)

IX. Relaxation:⁷ Breathing meditation.

XI. Stress scale.

XII. Any money left to collect?
Handouts: "Breathing Meditation".
"Multidimensional Aspects of Stress".

Week 2: Increasing your awareness of stress.
The physiology of stress.
Early Warning Systems (Multidimensional Aspects of Stress).

LECTURE NOTES:

1. Check-in: One common problem in groups is that people misunderstand the check-in, using it as a time to process problems, rather than as a way to bring focus to the group and let others know how you are doing. Introducing the check-in procedure with clarity is essential in this meeting to avoid this misunderstanding later. You may need to intervene if people ramble.

On the other hand, if an individual goes through a genuine crisis during the week (the diagnosis of a lover or friend, etc.), you may want to give them a little more time in the check-in.

It is also possible to do dyad check-ins the first few sessions of a group, where members pair up with a new partner each week and discuss the check-in topic or other concerns for 5-10 minutes. In this case, there is no group check-in.

2. Relaxation: Short PMR - Do a 5-minute version of the PMR.
3. Physiology of Stress: For better background on physiological responses to stress, consult any general handbook on stress reduction.
4. Three Stages of Stress: These concepts come from The Stress of Life by Hans Selye.

The Alarm phase is the event which first brings our notice to a stressor (a ringing bell, a shouting boss, a symptom of AIDS). The fight or flight response is stimulated.

In the 20th Century, most of our stressors are not things we can fight or flee, so we enter a stage of Resistance, where we resist the impulse to fight or flee. Often we never resolve the stressful situation. We continue to have the physiological stress response (Alarm), resist acting on it (Resistance), and ultimately reach a state of Exhaustion. In the third stage, physical, emotional or spiritual manifestations of imbalance may appear.

5. Early Warning Systems - The Multidimensional Aspects of Stress provide a structure for looking at the ways we manifest stress in our lives. Each dimension can be (1) a source of stress; (2) a signal about stress; or (3) a method through which we reduce stress and find relaxation. For example, we might have a negative thought about ourselves ("People don't like me") which is very stressful (a source of stress). Or we might find that when we are under a lot of stress, we tend to think such negative thoughts more often (a signal about stress). Finally, we can use our thoughts as ways to respond to that stress ("I feel like people don't like me, and I know I feel this way when I am under a lot of stress; I also know this is an irrational thought, and that I have a lot of good

friends who like me very much. I will spend some time thinking about my friends who like me instead of thinking about feeling disliked"). Thus, thoughts can be a method through which we reduce stress.

This same process can be followed with each of the other dimensions.

Some people will find that certain dimensions cause a lot of their stress, others might signal them about it, and others might be the best vehicle for reducing stress. For example, 1) AIDS in the environment causes stress. 2) A person might become aware of this stress when he or she recognizes obsessive thoughts about AIDS. 3) The person might then respond to the stress by exercise and relaxation techniques - physiology.

6. Discussion: As people discuss what has been stressful, try to tie it in to the Multidimensional Aspects of Stress (as in the explanation above). Point out what dimensions are relevant for individual group members as they speak, or ask others in the group to do this as a way of getting the discussion going.

In closing the discussion, point out that the first practical step in beginning a stress management program is becoming aware of when and how you experience stress in your life. Suggest that people continue to think about these dimensions through the week and pay attention to the ways they first become aware of stress. Remind them that the sooner they become aware of stress, the more effective their interventions for stress management will be.

7. Relaxation - "Breathing Meditation": (See instructions in "Handouts". Talk about meditation briefly, and ask who practices or has practiced meditation and what types. Explain that this exercise is a simple but effective form of meditation that addresses the breathing level of relaxation (of the three levels we mentioned earlier: body, breathing, mind). Most groups can tolerate (even enjoy!) this exercise for 10 minutes or so. A very anxious group might do better with a shorter period.

Guide the group in the exercise, and discuss briefly when finished. Ask if anyone fell asleep. Note that sleeping during meditation is a sign of tiredness, and that this is a fairly common occurrence. When people fall asleep, it may be a sign they need to get more rest.

Week 3: Change as a stressor.
Problem-solving.
AIDS-related stress.

GOALS:

1. Group members will become familiar with the idea that reactions to change may create stresses implicated in health functioning.
2. A model for problem-solving will be presented, and problem-solving will be suggested as a resource for stress management.
3. Personal experiences about AIDS will be used to suggest that AIDS has brought about many important changes and has created many problems to be considered.
4. A simple visualization technique will be learned.

STRESS MANAGEMENT GROUP - OUTLINE

Week 3: Change as a stressor.
Problem-solving.
AIDS-related stress.

I. Welcome.

Stress scale.

II. Check-in: What's been stressful this week? How did you know?

III. Relaxation: Short breathing meditation.

IV. Change as a stressor.

A. Theories and studies suggest change as a stressor which can compromise the immune system.

1. Many changes, especially major ones, seem to correlate with increased rates of illness.

2. "Positive" as well as "negative" changes are stressful; the goal is balance, not absence of stress.

3. Theories related to "life events questionnaires"¹

4. Latest research also suggests how you react to change (that is, your attitude towards change) is as important or more so than the actual changes you experience.²

B. Exercise:³ For five minutes, write down all of the changes you can think of that have happened over the last year.

Discuss (as a group or in dyads).

IV. Problem solving - One model.⁴

A. 1. Identify the problem.

2. Make a plan.

3. Implement the plan.

4. Evaluate.

B. Making a plan - The Seven A's:⁵

Alter - Change the situation.

Adapt - Change something about yourself.

Avoid - Stay out of the situation, or stay away from the problem.

Alternatives - Look for other ways to view the problem, or other possibilities in the situation.

Allow for the unexpected - Don't be too rigid about your expectations or how you approach the problem.

Action v. non-action - Decide carefully whether you need to do anything at the present time (eastern vs. western approach).

Acceptance - Accept that the situation exists (sometimes simply accepting something makes it less of a problem).

C. Discuss:⁶ - Think of a stressful event in the last week (perhaps the situation that came up during check-in). How did you deal with the situation? (That is, how did you problem-solve?)

VI. AIDS-related stress.⁷

A. Changes - AIDS had brought about tremendous changes in our personal, social and sometimes professional lives; in the lives of those around us; in our community.

B. Problems - AIDS creates many problems in our lives.

C. Discussion -

1. What are some of the changes you have experienced since the epidemic began?

2. Which of these changes have been problematic in some way?

3. What are some problem-solving approaches you have used or might use with these problems?

VII. Relaxation: Visualize PMR.⁸

VIII. Stress scale.

IX. Handouts: "Problem-solving".

LECTURE NOTES:

1. "Life events questionnaires" - Several groups of researchers, interested in the correlation of change with incidence of illness, have assembled questionnaires which give a numerical score to assorted life events. People filling out the questionnaires check whether or not an event has happened to them in the past year (or six months or two years, depending on which instrument one uses), add up their score, and see what their likelihood of experience serious illness in the next year (six months, two years) might be.

These questionnaires are useful in getting across the idea that "positive change" (getting a promotion, taking a vacation, etc.) is stressful. Unfortunately, there are other problems in using them in the groups. For one thing, some of the questions are not especially relevant to our clients (e.g. "wife beginning or ceasing work outside the home" is not an issue for women or most gay men). For another, we tended to have a few people in each group with astronomically high scores, and this only increased their anxiety and despair. Obviously, norms for these questionnaires were not established using an urban, gay population, and they are not accurate for our clients. We feel they are not useful for the groups we facilitate.

However, the concepts can be helpful, and some group members may be familiar with these tests, so you can mention them (and discuss the problems in using them) as you discuss the influence of change on health.

2. Many researchers have criticized life-events questionnaires for the same reasons we have. Their research suggests that how one reacts to change is as important or more so than the actual changes experienced. This is the essential concept to communicate to the group.
3. Exercise - In describing the exercise, encourage people to include minor as well as major changes, positive as well as negative events. The discussion can look at people's response to the changes. Do they see the changes as a challenge? A hassle? Something they can deal with? Something overwhelming? Do they have any sense whether change correlates with illness for them?
4. Problem-solving - When change creates a problem (and the problem, of course, creates stress), one approach to problem (and stress) management is Problem Solving. The model we present is probably similar to what people already do, whether they are conscious of it or not.

One of the most common difficulties in problem solving is with "Step 1 - Identify the problem". People often misidentify the problem and then come up with ineffective plans for problem solving. Ask people to share some problems they have experienced recently (without getting to solutions yet), and have the group help evaluate whether people correctly identify the problem.

For example, one client's problem was "I hate my job, and I need to quit and get into a new field." His identification of the problem (Step 1) was so vague and his plan (Step 2) so grandiose, he was immobilized and felt he couldn't change anything. Further exploration revealed that he had intense personality conflicts with his supervisor. This more specific problem suggested many more reasonable, concrete plans - e.g., (1) transfer to a new department; (2) ask for suggestions from his supervisor's boss about the problems; (3) seek some sort of third-party mediation; (4) wait until his supervisor was promoted out of the department; etc.

5. Making a plan: The Seven A's - Most plans will fall into one or more of the categories listed under the Seven A's. In the client example above, the first plan Altered the situation; the second looked at Alternatives; the third might have involved Altering, Adapting, Alternatives, or Allowing for the unexpected; the fourth Action vs. Non-action.
6. Discuss - Try to tie the discussion into the problem solving model.
7. AIDS-related stress - The discussion may naturally move along to this topic. If not, you can remind the group of the particular change and problem which have brought this group about - the AIDS epidemic.

Sometimes in discussing AIDS, members bring up overwhelming concerns or major problems. The "Problem-Solving" model may seem a feeble tool in the face of such powerful issues. By practicing these techniques on simpler problems, however, people can learn to use this approach successfully in very complex and intense situations.

Should the discussion in this (or any other) group session seem to become too grand for the technique at hand, you have at least two alternatives. One is to help people break a complex problem into simpler, more manageable components which can be used with the problem-solving model. Another is to go along with the intensity and acknowledge the immensity of AIDS in our lives, and to point out the need to practice these skills on a more modest level so we can learn to use this approach successfully in very complex and intense situations.

8. Relaxation - "Visualize PMR" - See instructions in Leader's Instructions for Relaxation Exercises. This is the first visualization presented in the group. Ask who has done visualizations before. Explain that visualizations involve the mind and the imagination in a relaxation technique, and that each person may experience these exercises differently.

As a short experiment to demonstrate this, ask people to close their eyes for a moment and imagine (1) a bell ringing (pause a few seconds between each suggestion); (2) smelling a rose; a skunk; (3) biting into a wedge of lemon; (4) seeing a seashore scene; (5) feeling a handful of sand from that seashore. Have people open their eyes and briefly state which was the most powerful image for them. Usually there will be some variety, and you can point out our individual differences in responding to visualization suggestions.

Guide the group in the exercise. Discuss briefly afterwards.

Week 4: Conscious sexuality.

GOALS:

1. Current guidelines for safe sex practices will be clarified.
2. The concept of "conscious sexuality" will be discussed.
3. Personal changes in sexual behavior made since the onset of the epidemic will be reviewed, and future changes that might be desirable will be considered.
4. Group members will have an opportunity to reflect on the impact AIDS has had on their sexuality (including sexual feelings, sexual relationships and sexual practices) and other related aspects of their lives (self-esteem and self-acceptance, self-identity, interactions with others, recognition of internalized homophobia, etc.).
5. A relaxation exercise using a partner will be learned.

STRESS MANAGEMENT GROUP - OUTLINE

Week 4: Conscious sexuality.

- I. Welcome.
Stress scale.
- II. Check-in: Any new thoughts about stress in your life?
(And, how has the week been generally?)
- III. Relaxation: Visualize PMR.
- IV. Clarifying safe sex guidelines.
 - A. Safe sex continuum exercise.¹

OR
 - B. Short lecture.²

OR
 - C. Guidelines exercise.³
- V. Conscious sexuality.⁴
 - A. Choices: generally: conscious vs. unconscious.
 1. Avoidance ("choices make themselves").
 2. Alcohol/drugs cloud consciousness.
 3. Other extreme physical/mental states can cloud consciousness.
 - B. Sexual choices specifically:³
 1. Sex as an altered state of consciousness.
 2. The importance of making health choices outside of an altered state -- not when having sex.
 - C. Decisions being made:
 1. What kind of sex?
 2. How much?
 3. With whom?
- VI. Role Plays [optional].⁶
- VII. Discussion.
 - A. How has AIDS changed your sex life?⁷
 1. Especially related to "Decisions being made," above.
 2. What has been easiest?
 3. What has been hardest?
 - B. Why do people have sex?⁸
 1. People generally.
 2. You personally.
 3. Do your reasons for having sex influence your ability to make positive sexual decisions in any way?

OR

C. Personal identity/sexual identity.⁹

1. History of gay identity/sexual identity.
 - a. Pre-Stonewall: Gay sexual identity was repressed, denied, hidden, punished.
 - b. After Stonewall: Gay identity was often linked with levels of sexual activity. "Gay is good," and being gay meant being sexual. Gay men set the stage for the "sexual revolution".
 - c. Late seventies: Different levels of activity were chosen by different individuals. Freedom of choice about sexuality was an essential part of gay identity.
2. AIDS affects the quality of choice regarding gay sexuality.
3. Crisis in sexual identity and personal identity arises.
4. Questions:
 - a. What are some ways AIDS has affected your sexual identity?
 - b. Have the effects on your sexual identity reflected on other aspects of your self identity?
 - c. What was the relationship of your sexual identity to your personal identity historically (especially before the AIDS epidemic)? How do they relate presently?

VIII. Future goals [optional].¹⁰

A. Discussion:

1. Would you like to make any changes in your sexual practices, sexual attitude or sexual identity? If so, what changes? If not, why not?
2. What are some ways you can move towards those goals?

IX. Closing.¹¹

X. Relaxation: Back-to-back breathing.¹²

XI. Handouts¹³: Condoms
Safe sex cards.

NOTES:

Once again, this seems to reflect the changing nature of the impact of AIDS. In the notes for this chapter, we offer descriptions of several of the different exercises and presentations we have used in our sex topic groups. There is considerably more material here than can be presented in one or two sessions. We suggest you evaluate the needs of your groups/community, and select those portions you feel will be most appropriate given their current feelings and knowledge about AIDS.

- Description:** On a blackboard or several large pieces of paper, draw a scale from 1 to 10. Explain that 1 designates totally safe sexual activities, 10 the most risky. Ask people to call out a particular activity and assign it a risk number. (For example, someone might say "sucking with climax: 6"). Write it down under that number, and ask if anyone disagrees with that (Someone says, "I'd call that a 4;" and someone else says, "What about pre-cum" I'd call it a 9"). Draw arrows showing the range of opinion. Your board would look like this:



When you have finished, discuss the scale. Usually, the most startling and obvious conclusion is that people disagree, probably quite a bit on the relative safety of various sexual activities (though usually there is good agreement about activities under "1"). This clearly suggests the necessity of being specific with potential sexual partners about acceptable activities - it isn't enough to say "I like to practice safe sex." One must also share one's opinion on exactly what "safe sex" means.

This is the time to clarify any misunderstandings people may have about levels of safety. For example, if someone says "fisting-receptive" is a 2, you might explain why most people would put it much higher. Scientific opinion about risk activities is not so varied as this "personal opinion" continuum might suggest. Though there is quite a bit of debate about "possibly safe guidelines, "unsafe" activities are clearly established. (Refer to Background Articles: "Safe-Sex Guidelines" for more information).

It is important to remember that while some clients may be clear about what behaviors are scientifically considered "safe," they may not feel safe emotionally engaging in these activities. Part of the discussion of this material might also focus on how to feel confident of one's decisions, or how to address generalized AIDS anxiety which might arise in sexual practices.

2. Short-lecture - You might want to develop a short didactic presentation on current guidelines, including an explanation of how the guidelines have changed over time and where scientific opinion stands at present. Ask any questions raised by the group, and clarify misunderstandings.
3. Guideline exercise - Hand out copies of current safe sex guidelines (see Resources section, p. 99). In pairs, small groups, or as a full group, have members write up their own guidelines. Are there ways to change this format that make the information more useful or more interesting to people? (Sometimes it is useful to think of different categories for such a list: things you do with your ass, things to do visually, etc.) Are there activities to add that do not appear in the "standard" guidelines? How complete a list can be developed? What would be the best way to communicate this information to people (or to gay men specifically)?
4. Conscious Sexuality - The AIDS epidemic has set forth new demands about personal decision-making. Conscious sexuality is a concept involving responsible, aware considerations about sexual practices. When we talk about sexual choices these days, we are talking about life and death decisions. The importance of this is evident.

We can talk first about choices generally. People tend to make choices in two general ways: consciously and unconsciously.

A conscious choice shows active considerations and a specific decision (e.g. - "I have Saturday off and want some time to relax, so I'm going to plan a walk on Mt. Tamalpais which I know I'll enjoy."). An unconscious choice is when we avoid making a decision, letting events happen as they will so that "choices make themselves" (e.g. "Well, it's Saturday already

and I don't have anything I have to do. Guess I'll just see what happens."). We are just as responsible for unconscious choices as we are for conscious choices. "No decision" is a decision!

Unconscious choices can be fun, healing, relaxing at times. In other cases - like in sexual encounters - they can be dangerous. It is important to evaluate whether or not an unconscious choice in a particular situation is a healthy option.

Another important element in decision-making is whether the consciousness is altered by alcohol or drugs (or fatigue, illness, anger, distress, etc. - any intense physical or emotional state). The clearest decisions are made with the clearest consciousness.

5. Sexual choices - It is important to recognize that sex is an altered state of consciousness, similar in some ways to being under the influence of drugs or alcohol. The heat of passion is not the time to make life-and-death decisions about behavior.
6. Role Plays - While gay men have communicated quite a bit about sexuality in the past, much of this communication has been indirect or non-verbal. Some group members might never have practiced talking directly about safe sex or setting limits with a partner. Our suggested role plays address these concerns. (While these role plays have been designed for work with gay men, they can be adjusted for use with other groups).

This is a good time to present communications models or discuss communications skills.

- A. Two men met in a bar and have decided to go somewhere and have sex. They are leaving the bar and talking about where to go and what to do. You might direct one of the men to maintain safe sex limits and the other to push for unsafe sex.
 - B. Two men have been sexual partners for two years and have had some unsafe and a lot of possibly safe sex. One partner wants to begin to have only safe sex and the other resists this change.
 - C. Two men have been dating for six months and have practiced safe sex. The relationship has grown deeper and the commitment is stronger. One of the men wants to begin having unsafe (or possibly safe) sex.
7. How has AIDS changed your sex life?

In this general discussion, many issues may arise. Two important concerns to mention over the course of the discussion:

- (1) Sex is a wonderful and powerful form of relaxation and stress management. Since the advent of AIDS, sex has become more associated with anxiety. For some people, sex is no longer a way to decrease levels of stress, but rather a source of new anxiety and stress. It is important to bring in new systems of stress management (such as those taught in this course) to replace old systems which may no longer be effective. In addition, however, learning to have anxiety-free safe sex is

a healthy and productive endeavor in establishing an effective stress management program.

- (2) Yes, safe sex is great. It is also essential to acknowledge the genuine losses experienced in changing sexual behaviors. For many people, coming to terms with AIDS-related sexual issues means dealing with the grief of giving up favorite practices. Depending on the nature of your group's discussion, you might want to review a model of grieving, including the different aspects of grief commonly experienced. (e.g. denial, anger, depression). For those dealing with sexual losses related to AIDS, such models may be quite helpful.
8. Why do people have sex? This is an opportunity to move the discussion into some of the influences on sexual decision-making which might be unconscious or indirect. The group can first identify some of the reasons people generally choose to be sexual (to feel good, to get attention, to express love, to express anger, to "let go", to have human contact, and so forth). If people can make the leap to the specific reasons they choose to be sexual, this discussion might illuminate obstacles to making or maintaining positive decisions about sexuality.
9. Personal identity/sexual identity - Sexual identity is one part of an individual's full personal identity. It concerns how one feels about sexual impulses, desires and attractions, level of sexual activity, sexual attractiveness, sexual orientation, gender, and so forth. It is influenced by culture, family history and individual personality.

Historically, gay men and lesbians were required to deny many aspects of their sexual identity. It was unsafe to be open about preferences; sexual feelings were often experienced in isolation; and sexual activity was commonly carried out in secrecy. Many gay people presented themselves as sexually neutral to the straight world, or feigned interest in opposite sex partners.

In the gay liberation era of the sixties, gay men in particular claimed certain rights about being open, demonstrative and active sexually. One's level of liberation was often measured by the amount of sex and number of partners one had had. Many gay men identified themselves as gay primarily through sexual behavior, and much of gay culture focused on this sexual aspect of identity.

During the late seventies, some of the pressure to be very active sexually changed, and different gay men practiced different levels of sexual activity. Much of what was special and exciting about being gay had to do with the option of being totally free to express sexuality however one wished. The choice of when, where, with whom and how to be sexual was no longer determined by the whims of heterosexual tolerance.

When AIDS appeared, this concept about sexual identity changed again. New constraints appeared in sexual choices, especially with whom, how and how often one had sex. The sense of sexual freedom changed. Ideas about sexual identity were shaken and, because of the unique history of gay people, AIDS touched the very core of self identity as well. Some clients have said, "If I can't be sexual the way I used to, how can I be

gay?" Dealing with AIDS and sexuality creates an identity crisis for many gay men.

9. Future goals - This discussion can be adapted to meet the needs of the group. It provides the opportunity to consider both behavioral and attitudinal changes in sexual practices. Sometimes AIDS prevention messages focus so strongly on behavioral concerns about sexual practices that we neglect the very important goal of feeling positive about and satisfied with our sexual choices. This issue may be addressed in this discussion.
10. Closing - A summary of the emotional materials brought to this group session is often useful, reflecting on the particular expressions of the group as a whole, and perhaps those of individual members as well. We feel it is particularly important to frame this process in a positive light. If this has been a difficult group, session, you might remind the members that facing these issues directly is one of the most effective ways of working the material through to a successful resolution. If issues seem unfinished, it may be useful to plan a follow-up segment on sexuality in the remaining weeks of the group.
11. Relaxation - "Back-to-back breathing" - See instructions in Leader's Instructions for Relaxation Exercises.
12. Handouts - Safe sex kits or condoms add a playful note to this group. Current articles or publications ("How to have a hot J.O. party in your own home," etc.) may also be useful. We usually hand out whatever we have that is current and relevant to the group topic.

Note: During the session, The AIDS Health Project often uses media resources as an adjunct to the group. Erotic safe sex videos or slide shows or other media materials can contribute an element of fun to the group. Safe sex video materials are being developed for gay men and other groups by different organizations. For further information, see Resources: "Safe sex audio-visual materials."

Week 5: Cognitive aspects of stress.
The stress of homophobia.

GOALS:

1. The progress of the group will be evaluated, and an assessment made of whether members' needs are being met.
2. A cognitive framework for understanding and dealing with stress-provoking thoughts will be introduced.
3. The links between homophobia (a cognitive phenomenon) and AIDS will be discussed.
4. A new breathing exercise will be learned.

STRESS MANAGEMENT GROUP - OUTLINE

Week 5: Cognitive aspects of stress.
The stress of homophobia.

- I. Welcome.
Stress scale.
- II. Check-in: What's been stressful about sexuality this week?
- III. Relaxation: Short breathing meditation.
- IV. Midpoint evaluation.¹
 - A. How do you feel about the group?
 - B. What do you like about it?
 - C. What would you like to get that you aren't getting now?
- V. Cognitive aspects of stress.
 - A. Description of thoughts, their power and usefulness.
 1. Define thoughts as "sentences we tell ourselves."
 2. They are always with us.
 3. We have a fair amount of control over what we think.
 4. Working with thoughts is private -- other people do not know what you're thinking unless you tell them.
 5. Thoughts can both create and relieve stress in our lives.
 - a. Example: Going to bed late and saying "I know I'm going to be exhausted when I wake up in the morning;" vs. saying, "I will wake up refreshed and energetic."
 - b. Other examples from the group?
 - B. Six types of thinking:²
 1. Positive.
 2. Negative.
 3. Constructive.
 4. Destructive.
 5. Necessary.
 6. Unnecessary.
 - C. Common errors of thinking:²
 1. Exaggerating.
 2. Overgeneralizing.
 3. Ignoring the positive.
 4. Pessimism.
 5. Blaming oneself.
 6. Not giving oneself credit.

- VI. Homophobia: a cognitive phenomenon.
 - A. Society learns it and teaches it (external homophobia).
 - B. We learn it (internalized homophobia).
- VII. Discussion:³ What are some of your personal experiences with cultural homophobia? With internalized homophobia? With AIDS-related homophobia? With AIDS-phobia?
- VIII. Relaxation Exercise: Counting Breaths Backwards.⁴
- IX. Stress scale.
- X. Handouts:
 - A. Six Types of Thinking.
 - B. Common Errors of Thinking.
 - C. Ways to Change Harmful Thoughts.

Week 5: Cognitive aspects of stress.
The stress of homophobia.

NOTES:

1. Midpoint evaluation - An informal evaluation of the group by participants.
2. Six Types of Thinking - and Common Error of Thinking - Refer to Handouts, "Six Types of Thinking" and "Common Errors of Thinking." Involve the group in discussion of personal examples of "Six Types of Thinking" and "Common Errors of Thinking."

There is also a third handout on "Ways to Change Harmful Thoughts." It is usually difficult to cover all of these cognitive materials in one group. This last set of materials can be used as a handout only, or as a follow-up to the presentation in a subsequent week.

3. Discussion - In most groups, this will not be the first time the issue of homophobia, including internalized homophobia, has been raised. You can refer here to earlier discussions if appropriate.

Homophobia is an excellent example of an cognitive (learned) phenomenon with emotional consequences. It can provide a powerful illustration of the inter-relationships of cognitive and emotional processes.

We believe that societal homophobia, and the internalized homophobia gay people develop as a consequence of being raised in a homophobic culture, influence many of the feelings people have about AIDS. Most gay men have probably wondered at some point, even in passing, whether AIDS is indeed some sort of punishment for being gay, for being sexual. These are painful thoughts and feelings. Try to provide in this discussion a non-judgmental atmosphere for the expression of these feelings, as well as advocacy for those who have experienced some of the horrible AIDS-based discrimination we hear about (or experience ourselves) so often.

4. Relaxation - "Counting Breaths Backwards": See instructions in "Leader's Instructions for Relaxation Exercises."

Week 6: Setting up your own stress management program.

GOALS:

1. Group members will begin to develop specific measurable goals to establish a general stress management program.
2. "A Safe Place" visualization exercise will be learned.

STRESS MANAGEMENT GROUP - OUTLINE

Week 6: Setting up your own stress management program.

- I. Welcome.
Stress scale.
- II. Check-in: How's your level of stress been this week?
- III. Relaxation: Counting breaths backwards.
- IV. Short review - Styles of stress management we have covered thus far in group:
 1. Increasing awareness of stress; early warning systems.
 2. Problem solving.
 3. Cognitive aspects of stress.
 4. Sexual issues; sex as a stress management tool.
 5. Relaxation exercises: Releasing muscle tension (PMR).
Relaxing breathing (meditation).
Quieting mind (meditation;
visualizations).
- V. What are some other styles of stress management we have not discussed or covered here? (Ask group for ideas).
Some suggestions: Being with friends.
Listening to music.
Exercise.
Relaxing or escapist activities like
movies, books.
Being in the country, at the beach.
Laughter.
- VI. Setting Up Your Own Stress Management Program¹
 1. Have group fill out handout exercise, "Setting Up Your Own Stress Management Program".
 2. As people finish, set up pairs to discuss their results. Suggest that people make agreements about changes in their stress management program they could make this week; cover the concept of specific, measurable behavioral goals.
 3. Group discussion. Reaction to form; any revelations; have people go over their planned changes for the week and encourage the group to give feedback about the plans.
 4. "We will follow up on this during check-in next week."
- VII. Relaxation: Visualize A Safe Place.²
- VIII. Stress scale.
- IX. Handouts: Setting Up Your Own Stress Management Program (exercise filled out during group).

Week 6: Setting up your own stress management program.

NOTES:

1. One of the goals of this group is for members to have some specific tools and plans for stress management in their lives by the time the group ends. Today's exercise helps us toward this goal.

Pairs can discuss the exercise for 10-20 minutes. Suggest that partners help each other out in assessing needs and planning action. "Specific, measurable behavioral goals" are actions which can be described, quantified, and verified. For example, "I will go to the gym" - action described - "three times this week" - action quantified. At the end of the week there should be no question whether or not the action was done - it is verified.

Help people out during the group discussion of plans. The most common problems with plans:

- (1) Too vague: "I'm going to exercise." What kind of exercise? For how long? How often?
- (2) Too grandiose: "I'm going to settle all my conflicts with my roommate." Choose one specific conflict this week. What can you do about it? When will you do it? How will you know if you've succeeded in resolving the conflict?
- (3) Too demanding: "I'm going to meditate for one hour every day this week," from someone who currently does not meditate at all.

Talk about the need to start with goals you are sure you can achieve so you start making change with a successful experience.

2. Relaxation - "A Safe Place" - See instructions in Leader's Instruction for Relaxation Exercises. Before beginning this exercise, you might want to remind the group that they have ultimate control of their own visualizations. If anything is ever suggested by the leader which is uncomfortable to someone, he or she should feel free to ignore the suggestion or change it in a way that makes the situation more acceptable. A good example of this is the time we suggested that people in the group imagine themselves descending in an elevator, becoming more relaxed as each floor passed. A group member who was phobic about elevators simply watched himself walking down a staircase instead.

Week 7: Social Support Networks

GOALS:

1. The influence of social networks on health status will be presented.
2. The special history of social isolation of gay people and its implications in the AIDS epidemic will be discussed.
3. Group members will evaluate their own social support networks and consider behaviors that might enhance the positive functioning of those networks.

STRESS MANAGEMENT GROUP - OUTLINE

Week 7: Social Support Networks

[Note: This is a good session to catch up on any materials that were not fully covered over the course of the group. Use of this outline can be quite flexible.]

- I. Welcome.
Stress scale.
- II. Check-In: Follow-up on stress management plans made during last session.
- III. Relaxation: Short "Safe Place" visualization.
- IV. Social Support:
 - A. Research about social support:
 1. People with more friends and better quality friendships tend to have less illness, greater longevity, and greater life satisfaction than those with fewer and poorer quality friendships.
 2. Possible implications for immune functioning (people are healthier when they feel good about their network of social support).
 3. Examples: Pet programs for the elderly (people involved in these programs have less sickness and report greater satisfaction with their lives).
 - B. History of social isolation as gay people.¹
(Special Issues of Isolation for urban people.)
 - C. Need for support in dealing with the AIDS situation.²
 - D. Exercise: Have a party/have a problem.³

In pairs, have group informally discuss the questions posed on the worksheets.
- V. Discussion:
 - A. What did you discover about your support networks in doing this exercise?
 - B. What do your friends do for you? How do they affect the quality of your life?
 - C. How do your own attitudes or practices either help or hinder the quality of your relationships?
- VI. Relaxation exercise: "Back to Back Breathing" OR "A Pebble Drops".⁴

VII. Stress scale.

VIII. Handouts:

- A. Have a Party! (handed out during group).
- B. Have a Problem? (handed out during group).

NOTES:

1. The isolation and separation of gay people, common in the past, began changing with the gay rights movement in the Sixties. Some public and political response to AIDS brings up the possibility of further repression and isolation of gay men (and women). Do group members foresee this happening?
2. The need for social, community, and political support is immense. Probably most important on the personal level is the support available from friends.
3. Exercise: Have a party/have a problem - The two worksheets are included in the Handouts section. One focuses on what sort of support system a person likes, the other more on what support a person actually has. At facilitator's discretion, either or both worksheets may be used.
4. Relaxation: "Back-to-Back breathing" or "A Pebble Drops" - See instructions in Leader's Instructions for Relaxation Exercises.

Week 8: Evaluating stress management plans.
Review and evaluations.
Goodbyes.

GOALS:

1. To review and assess the materials presented in the group, the skills of the facilitator(s), the general success of the group.
2. To review and assess personal progress in stress management planning.
3. To finalize future goals, short or long term, for stress management.
4. To examine personal styles of saying good-bye in other settings, and to say good-bye to the group.

STRESS MANAGEMENT GROUP - OUTLINE

Week 8: Evaluating stress management plans.
Review and evaluations.
Goodbyes.

[Note: This is a good session to bring in any current materials that are not included in this course or respond to any special requests made during the mid-point evaluation. Use of this outline can be quite flexible.]

- I. Welcome.
Stress scale. Discuss stress scale - function and purpose.¹
- II. Check-in: How do you feel about the group ending?
- III. Relaxation: Have group do an exercise silently on their own for about five minutes.

Discuss: What did you do? How did it work?
- IV. Program evaluation:
 - A. Written (confidential).²
 - B. Verbal.³
 - C. Sign up on mailing list, or indicate interest in further programs or future groups.
- V. Personal evaluation: How do you evaluate your personal progress in this group, especially regarding?
 - A. Level of stress and what you're doing about it.
 - B. AIDS-related stress.
 - C. Any other issues.
 - D. What is your future direction for stress management? Will you be doing more or less of anything?
- VI. Saying good-byes.
 - A. Different styles of saying good-bye for different people.
 - B. Many of us have said a lot of good-byes recently:
 1. To friends who have died.
 2. To sexual practices.
 3. To a social lifestyle that has changed.
 - C. Each member of the group has his/her own style of saying goodbye.

- VII. Discussion: What is your personal style of saying good-bye?
How have you said good-byes in the past? How
would you like to say good-bye to this group?

Remind people that though this is the end of the group, it
does not need to be the end of their contact, and they can
continue to meet with one another outside the group.

- VIII. Relaxation exercise: "Colored Light Visualization," "Group
Circle/Connection Exercise," or repeat a visualization that group
especially liked.⁴

- IX. Handouts:

A. Evaluation forms (filled out during group and returned).

Week 8: Evaluating stress management plans.
Review and evaluations.
Goodbyes.

NOTES:

1. Stress scale - Group members can keep their stress scales this week. Usually people will notice two general trends on their scales: (1) they are more relaxed at the end of the group (after a relaxation exercise) than at the beginning; and (2) their general level of stress has decreased since beginning the group. These trends are by no means universal.

The true goal of the stress scale is simply to heighten awareness of stress, recognizing that awareness is the first step toward stress reduction.

2. Written evaluation

We use two written evaluation forms for AHP groups - the Client Satisfaction Questionnaire (a standardized, objective form), and our own narrative Evaluation Form (see example in Handouts). These allow clients to offer confidential evaluations of the group.

3. Verbal evaluation

We usually ask for general feedback about the group and the facilitators, and specifically ask what was most useful, what was least valuable, what would people have liked to see in the group that was not there, etc. These evaluations are quite helpful in updating the groups. As the qualities of the AIDS epidemic change, the materials in the groups are revised.

4. Relaxation - "Colored Light Visualization" or "Group Circle/Connection Exercise": See instructions in Leader's Instructions for Relaxation Exercises.

LEADERS' INSTRUCTIONS FOR RELAXATION EXERCISES

[Note: These instructions are not generally handed out during the groups because it has not seemed necessary to do so.]

Contents: Standard inductions for group relaxation
Visualizing Progressive Muscle Relaxation.
Counting Breaths Backwards.
Back to Back Breathing.
A Safe Place.
A Pebble Drops.
Colored Light Visualization.
Group Circle/Connection Exercise.

The following exercises are in the
Handouts section:

One Full Breath.
Progressive Muscle Relaxation.
Breathing Meditation.

STANDARD INDUCTIONS FOR GROUP RELAXATION EXERCISES

1. Five-Count Breathing

I'd like you to sit upright in your chair, feet flat on the floor, spine erect and supporting itself. Bring your attention to your breathing. And now bring your attention to your exhalations, letting yourself release tension and negativity with each breath you exhale. Each time you release your breath, you feel more and more deeply relaxed. [Pause for a minute.]

Now I'd like you to begin a special breathing pattern, where you inhale and hold your breath for a count of five, [pause], then release your breath slowly over a count of five, [pause], and then hold without breathing for a count of five. Repeat this several times to yourself: inhale and hold for a count of five, exhale slowly over a count of five, then hold without breathing for a count of five. [Pause for three or four minutes.]

Now I'd like you to resume normal, relaxed breathing. Take a moment to notice that you are deeply and comfortably relaxed.

[Proceed with visualization or other exercise of your choice.]

2. Counting Backwards

I'd like you to sit upright in your chair, feel flat on the floor, hands in an open and receptive position on your laps, spine erect and supporting itself. Bring your attention to your breathing. And now bring your attention to your exhalations. Each time you exhale, allow yourself to release tension and negativity. With each breath, you feel more and more deeply relaxed. [Pause for a moment.]

Tell yourself that any outside noise or distractions will only serve to increase your sense of relaxation.

I'm going to count slowly backwards, from 10 to 1. With each descending count, you will find yourself becoming more and more deeply relaxed. 10...[pause]...9...[pause]...8...etc. 2...[pause]...1.... Now you feel comfortable, calm, and deeply relaxed.

[Proceed with visualization or other exercise of your choice. To end visualization, you can say the following:]

I'd like you to remind yourself that any time you want to return to this deep and comfortable place of relaxation, you will find the exercise easier to do and you will be more deeply and fully relaxed when you do it. Now I'm going to count slowly, from 1 to 10. With each ascending count, you will find yourself continuing to feel calm and relaxed, and also feeling more alert and energized. 1...[pause]...2...[pause]...3...more alert...4...more energized...5...relaxed...6...[pause]...7...alert...8...more aware of your surroundings...9...aware of the room and the people around you...10...and when you are ready, you can open your eyes.

3. Elevator

I'd like you to sit in your usual relaxation posture, feet flat on the floor, spine erect and supporting itself comfortably, hands in an open position on your lap. Bring your attention to your breathing...and then bring your attention to your exhalations. As you exhale, allow yourself to release any tension, any tightness that you might be feeling...so that with each new breath, you feel more and more relaxed.

Tell yourself that any outside noise or distractions will only serve to increase your sense of relaxation.

Now I'd like you to imagine yourself in an elevator. Notice what the elevator looks like, where you are standing, how it feels. You see the lights over the door, and they indicate that you are on the tenth floor. You push the button for the first floor. The elevator begins to move and the lights show each floor you pass as you descend. With each descending floor -- the ninth, the eighth -- you find yourself growing more and more deeply relaxed. Watch the lights now, as they take you down to the first floor. [Pause.] When you reach the first floor, you feel quite comfortable and relaxed.

[Proceed with the visualization of your choice. Be sure to help people visualize themselves leaving the elevator! To end the visualization, you can say the following:]

Imagine yourself once again entering the elevator we began this exercise with. Once again you see the lights over the door, showing that you are on the first floor. The doors close, and you push the button for the tenth floor. Again the elevator begins to move, and the lights indicate each floor as you pass. With each ascending floor -- second, third -- you continue to feel calm and relaxed, and also find yourself growing more alert and energized. Watch the lights now as they take you up to the tenth floor. [Pause.] When you reach the tenth floor, keep your eyes closed for a moment more, noticing this sense of calm, energized alertness you are experiencing. Remind yourself that you can keep this sensation with you throughout the remainder of your evening. Bring your attention once again to your surroundings, the people around you, the people on either side of you...[pause]...and when you are ready you can open your eyes.

VISUALIZING PROGRESSIVE MUSCLE RELAXATION instructions

Sit in your relaxation exercise posture: feet flat on the floor, spine erect and supporting itself, hands folded gently in your lap or facing up on your thighs.

Bring your focus to your breathing, and then to your exhalations, allowing yourself to release tension and negativity as you exhale.

Begin the special breathing pattern by taking in a deep, gentle breath and holding it for a count of five; then release the breath slowly over a count of five; then hold without breathing for a count of five. Repeat this sequence several times to yourself.

Now I'd like you to resume normal, relaxed breathing.

I'd like you to imagine a feeling of warmth around your feet, beginning with your toes...then over the top of your feet and under your feet...up around your heels and up to your ankles....Continue to imagine that warm, relaxing sensation as it travels on up your legs, over shins, calves, up to your knees....If you are having any trouble feeling the warm sensation, just make it up...pretend that you can feel it. The warmth continues to travel over and under your knees, into your thighs...along up to your buttocks, sphincter, genitals...into your visceral organs....Now imagine that warm sensation coming into your lungs with each breath you take, so that your body is filled with a sense of warm, gentle relaxation...entering your bloodstream...moving all through your body....The warm continues up to your shoulders and up along your spine, then down your arms, upper arms, forearms, down to your hands until you can feel the warmth all the way to the tips of your fingers.... Then let the warmth move up along your neck, over the top of your head, and over your forehead and face. So that now you have a sense of your entire body, inside and out, being surrounded by a warm, calming, relaxing sensation.

Let yourself sit for a few moments simply enjoying this calm, relaxed state.

I'm going to count from one to five. With each ascending count, you'll find yourself growing more aware of your surroundings, more alert and energized. One...two...three...feeling more alert...four...more energized...and five. Keeping your eyes closed for a moment, remember the people around you; the people on either side of you; and when you are ready, open your eyes.

Sit in your relaxation exercise posture: feet flat on the floor, spine erect and supporting itself, hands folded gently in your lap or facing up on your thighs.

Bring your focus to your breathing, then to your exhalations, allowing yourself to release tension and negativity as you exhale. Remind yourself that any outside noise or distraction will only serve to increase your sense of relaxation.

Begin the special breathing pattern we have practiced here already -- inhaling and holding for a count of five; exhaling slowly over a count of five; then holding, without breathing, for a count of five. Repeat this several times to yourself.

Now you can resume normal, relaxed breathing.

Bring your focus again to your exhalations. I'd like you to begin to count your exhalations, beginning with the number ten and descending, with each breath, to the number one. With each descending count, allow yourself to go into a deeper and deeper state of relaxation, until, at the count of one, you are fully, deeply relaxed.

(Pause for count.)

When you reach the number one, allow yourself to sit for a few moments in this state of total, comfortable relaxation. (Pause for a few minutes or more.)

I'd like you to remind yourself that any time you want to return to this state of relaxation, you will find it easier to do and you will be more deeply relaxed when you do it. (Pause.)

I'd like you to bring your focus again to your exhalations, and begin counting your exhalations beginning with the number one and continuing with an ascending count until the number ten. With each ascending count, you will find yourself feeling more alert and energized, while continuing to feel deeply relaxed. (Pause for count.)

When you reach the number one, continue to sit for a few more moments with your eyes closed. (Pause.) Bring your awareness again to your surroundings...to the people around you...to the people on either side of you...and when you are ready, you can open your eyes.

BACK TO BACK BREATHING instructions

Have people choose partners and then find a comfortable place to sit back to back. Some people cannot sit on the floor comfortably (because of physical limitations or injuries), so suggest that some might want to arrange their chairs so they can sit back to back.

When people are arranged in position, begin the directions.

DIRECTIONS:

I'd like you to bring your attention to your breathing, and then to your exhalations. And as you focus on your exhalations, you can think about releasing tension and negativity with each breath.

Begin the special breathing pattern by taking in a deep, gentle breath and holding it for a count of five; then exhaling slowly over a count of five; then holding, without breathing, for a count of five. Repeat this sequence several times to yourself.

Now I'd like you to resume normal, relaxed breathing. Continue to breathe, focusing on your exhalations, and allowing yourself to enter a calm, relaxed state. Notice what it's like to share this experience with your partner. Are you aware of his or her breathing patterns? Is your partner's breathing quiet and subtle, so that it is difficult to sense his or her patterns? Don't force anything...just see what you are aware of.

[Optional]

Continue to breathe in a normal, relaxed manner. I'd like you to think of a color...whatever color comes to mind...and imagine yourself breathing that color. With each inhalation, you take that color into your lungs, and with each exhalation you breathe that color out of your lungs. If you have any trouble seeing a color, just make it up. Pretend you can see it.

Imagine that color growing around you, so that soon you are surrounded by an aura or a light of that color, as you continue to breathe in, breathe out...Now let that color expand, so that it surrounds your partner. Allow the color to envelope the two of you. For a few moments, just experience your breathing, your color, letting that color surround you and your partner.... Now let the color expand again, so that you are sending the color, the light, out to the entire room, to all the people in the room...Feel what it's like to send the color out.... And notice what it's like to have the energy of others coming back to you.

Allow the color to come back to you and your partner... and then to you...and back to your breathing. Focusing again on your exhalations.

AIDS HEALTH PROJECT
Stress Management Training
"Back to Back Breathing" instructions

I'm going to count from one to five. With each ascending count, you'll find yourself growing more aware of your surroundings, more alert and energized. One....two....growing more alert....three....more energized....four....five. Keeping your eyes closed a moment more, let yourself become aware of the people around you, the people on either side of you, and when you are ready, you can open your eyes.

A SAFE PLACE instructions

[Have group enter a state of relaxation by whatever method works best for you with visualization exercises.]

Now I'd like you to imagine that you are walking along a path. Notice what it feels like as first one foot, and then the other, falls upon the path. Notice what shoes you're wearing, the pace at which you walk, the weather around you, the clothing you wear....the smells...the sounds. Continue walking along, paying attention to what you see as you do so. (Pause.) Up ahead, you notice a place that looks like a good place to stop, so you approach it and find a comfortable place to sit. Let yourself rest. Feel what it's like to sit still rather than walk. (Pause.)

I'd like you to begin to notice some of the details around you. What sort of place is this that you're in? Let it be a place that feels very comfortable and very safe to you. Think of all the things you might need to feel safe, comfortable, at ease. Let these things into this space....

Notice how you're sitting, and what you're sitting on... Allow your eyes to look to the left. What do you see?... Now look in front of you, noticing the things around you. Continue to move your gaze, to the right now...Then look above you. All around you, you are surrounded by whatever makes you feel most safe, most comfortable, most at ease. (Pause.)

Let yourself enjoy this relaxing moment in your safe place, surrounded by things that make you comfortable. (Pause.)

As you sit, enjoying this safe place, you hear someone or something approaching. You do not feel any fear. Instinctively, you know whatever it is that approaches you will help, not harm you. You look to see what it is. A wise old person [or "spirit animal," or "wise being,"] comes into your view, approaches you...You may ask this person a question if you wish. You think about what you might want to ask...If you do have a question to ask, ask it now, and listen or watch for the answer. (Pause.)

It is time for the wise person to leave now. Remind yourself that anytime you wish to speak to this person again, you can come back to this place and do so. Watch the person walk away again. (Pause.)

[Optional-----]

AIDS Health Project
A SAFE PLACE instructions
-2-

Soon it will be time to leave your safe place. In these last few moments, I'd like you to remind yourself that anytime you want to come back to this place, you will find it easier to do, and you will feel more deeply relaxed as you do so. (Pause.)

Stand up, and look around once more at this special, safe place. If there is some small object you would like to bring with you as you leave, pick it up and put it in your pocket.

Begin to walk once again along the path.

[Take group out of the relaxation by whatever method works best for you with visualization exercises.]

A PEBBLE DROPS instructions

[Have group enter a state of relaxation by whatever method works best for you with visualization exercises.]

Now I'd like you to imagine a deep, cool, clear pool of water. In the pool of water, a small pebble slowly, calmly, drifts towards the bottom of the pool. Watch it as it moves, against the force of the water, making its way along whatever path is easiest...As the pebble continues to descend, you find yourself feeling more deeply relaxed.... The pebble moves deeper...your relaxation is deeper.... (Pause.)

You can see the bottom of the pool now. A clean, calm, sandy bottom. Watch the pebble as it approaches the bottom of the pool, drifting, slowly, and at the point at which it softly touches and becomes still, you find yourself at a point of total, deep, comfortable relaxation... (Pause.)

Just enjoy this calm, quiet, comfortable moment...(Pause.)

[Take group out of the relaxation by whatever method works best for you with visualization exercises.]

[Guide the group into a state of deep relaxation by whatever method works best for you with visualizations.]

I'd like you to think of a color. A color that is comfortable, relaxing to think of. See it in your mind's eye....If you have any trouble seeing the color, just make it up.

Then I'd like you to imagine a small point of light of this color, sitting just above your head.... Gradually let this light grow in size, so that your body begins to be enveloped by this colored light....Let the light enter your body with each breath, let it come into your lungs, enter your blood stream, reach all the places inside you. You can see yourself sitting here, with the light glowing inside and outside of you....(Pause.)

Now let the light expand again, so that it shines around the other people in the room. Imagine each person in turn, surrounded by the healing, relaxing light. As you continue to see this, the light grows and grows until it fills the room...

Let the light grow again, so that it is shining around other people who come to mind....Friends, family... acquaintances....And let it continue growing until all of San Francisco is surrounded and bathed in this light....Relaxing, healing, loving light.

The light can continue growing, until it reaches through the state, throughout the country, around the entire planet....See the planet glowing with your colored light...

You can begin to gradually pull the light back in again...seeing it grow smaller and smaller until it only fills this room...glowing around the people in this room...glowing around you. And now you see the light become a small point of color, floating above your head once again.

[Bring the group out of the relaxation state by whatever method is comfortable for you.]

CLOSING CIRCLE EXERCISE

[Have group members stand and join arms in a circle. Make any general or specific comments that seem appropriate, about endings, goodbyes, the experiences of the group, etc. Other people in the group may wish to speak as well. When it seems like it is time to finish, say...]

I'd like you to bring your awareness to the feelings of your arms around other group members...to the energy in this circle...to the connections between us all as we stand here, arm in arm. Slowly, gradually, let yourself begin to move away from the closeness of the group. Our bodies move apart from one another...our arms reach out, touch, let go.... Imagine the interconnecting network that continues to exist between us, even without physical contact.... Imagine that connection reaching out to other people...[name any group member who has been unable to attend the group meeting]...to your friends, family...to the other people you know...to people you don't know. The connections continue, unseen.

HANDOUTS FOR GROUP MEMBERS

Contents: Stress Scale.
 One Full Breath (relaxation).
 Progressive Muscle Relaxation.
 Breathing Meditation (relaxation).
 Multidimensional Aspects of Stress.
 Problem Solving.
 Six Types of Thinking.
 Common Errors of Thinking.
 Ways to Change Harmful Thoughts.
 Setting Up Your Own Stress
 Management Program.
 Have a Party!
 Have a Problem?
 Group Evaluation.

Name _____

STRESS SCALE: This exercise can help you increase your awareness of your own stress. Imagine a scale of 1-10, with 1 being the most relaxed you have ever been, and 10 being the most stressed you have ever been. Think about where you would place yourself on that scale this moment.

Each week of this course, we will ask you to fill out this stress scale, both at the beginning and the end of the group. Put an "X" on the scale showing your level of stress at the beginning of the session. Put an "O" on the scale at the end of the session.

You can jot down any notes you might want to about what has been especially relaxing or stressful for you in a particular time period.

Turn in the sheet at the end of the group.

	Low									High	
	1	2	3	4	5	6	7	8	9	10	
Week 1											
Week 2											
Week 3											
Week 4											
Week 5											
Week 6											

NOTES:

One Full Breath

Becoming more conscious of your breathing can also help you become more aware of when you are feeling stress. This exercise allows you to experience a single, full, relaxing inhalation/exhalation cycle. It takes only a moment and can be done standing, sitting or lying down.

Instructions:

1. Exhale deeply. Feel the muscles in your abdomen contract as the air is released.
2. Inhale slowly. Expand your abdomen.
3. Continue inhaling. Expand your chest.
4. Continue inhaling. Raise your shoulders gently towards your ears.
5. Hold for a few, comfortable seconds.
6. Exhale slowly. Reverse your actions: feel your shoulders gently lower, your chest gently contract, your abdomen gently contract.
7. Resume normal breathing.

Hints:

1. Practice gently. It may take a few days to get the sequence smooth and comfortable.
2. Consider doing this exercise when you are conscious of being tense. You might end up doing this several times a day.

Variations:

1. After some practice, you can repeat this sequence several times. Take it easy so you don't hyperventilate.
2. Once the sequence is clear and you are comfortable with it, consciously think about releasing tension and negativity as you exhale. Say to yourself, "I am releasing all tension and negativity," or some similar phrase.

Progressive Muscle Relaxation

People sometimes feel anxious about their thoughts or events around them. When this happens to you, you develop a physiological tension which increases your sense of anxiety. Progressive muscle relaxation (PMR) can break this cycle of increasing anxiety by providing deep muscle relaxation that is incompatible with anxiety. It is useful in dealing with muscular tension, anxiety, insomnia, depression, fatigue, muscle spasms, neck and back pain, constipation and high blood pressure.

Two exercises are described: the Full Procedure and the Short Procedure. The Full Procedure will provide deeper relaxation and is especially important when first learning the technique. The Short Procedure is useful once you are familiar with PMR, allowing significant relaxation in a brief period of time.

Plan to spend 15 minutes, twice a day, for a couple of weeks to learn this well.

Position:

This works best sitting in a hardback chair, but can be done in other settings as well.

Instructions:

1. Clench your right fist. Clench it tighter and tighter. Notice the tension. Notice your fist, hand, forearm. Hold it for a count of 5. ("One, two, three, four, five...") Now relax. Feel the looseness in your hand. Compare this with the feeling of tension.

Repeat.

Repeat with left fist. (Tense, hold, relax. Tense, hold, relax.)

Repeat with both fists at the same time.

2. Bend both elbows and tighten your biceps. Tighten them harder and harder. Notice the tension. Hold for a count of 5. Now relax and straighten out your arms. Feel the looseness and relaxation in your arms. Compare this with the feeling of tension.

Repeat.

(cont.)

3. Think about your head. Imagine all the features of your face pushing in towards your nose. Close your eyes tight. Pull your forehead into a frown. Push your mouth up towards your nose. Tighten your jaw. Feel your tongue push against the roof of your mouth. Push, push, tighter and tighter. Hold for a count of 5. Now relax and feel your face become smooth and relaxed. Compare this with the feeling of tension.

Repeat.

4. Press your head back as far as it can comfortably go. Feel the tightness in your throat and neck. Lift your shoulders. Tighter, tighter. Hold for a count of 5. Now relax and notice your neck, throat and shoulders. Compare this with the feeling of tension.

Repeat.

5. Press your head forward so your chin is pushing against your chest. Lift your shoulders. Feel the tightness in your neck. Tighter, tighter. Hold for a count of 5. Now relax and notice your neck. Compare this with the feeling of tension.

Repeat.

6. Give your entire body a moment to relax. Take in several deep, comfortable breaths. Take in a breath and hold it for a count of 5. Then release it and breath normally again. Compare your deep breathing with the feeling of tension when you hold your breath.

Repeat a few times.

7. Tighten your stomach. Feel all your organs tightening inside. Tighter, tighter. Hold for a count of 5. Now relax. Notice your stomach and other organs. Compare how they feel now with the feeling of tension when you tightened the muscles.

Repeat.

8. Push your legs towards one another. Feel your thighs, buttocks and calves tighten. Push, push, harder and harder. Hold for a count of 5. Now relax. Notice the feeling of relaxation. Compare this with the feeling of tension.

Repeat.

(cont.)

9. Lift your legs in the air and tighten them. Curl your toes towards your body. Feel the tightness in your calves and thighs. Tighter, tighter. Hold for a count of 5. Then relax and gently lower your legs to the ground again. Notice the feeling of relaxation. Compare this with the feeling of tension

Repeat.

10. Sit for a moment feeling the heaviness of your relaxed, comfortable body. Spend a little time thinking about your feet, your ankles, your calves, shins, knees, thighs, buttocks. Feel more and more relaxation. Now think about your stomach, lower back, your chest. Let go of tension and feel more and more relaxation. The relaxation deepens in your arms, your hands. Notice relaxation in your neck, jaw, and your face.

Take a few comfortable, deep breaths.

Instructions: Short Procedure

1. Curl both fists, tighten your arms, pull your fists towards your shoulders and hold for a count of 5. Relax. Repeat.
2. Imagine all the features of your face pushing in towards your nose. Push your muscles towards your nose. Hold for a count of 5. Relax. Repeat.
3. Tighten your stomach and other organs. Hold your breath. Hold for a count of 5. Relax. Repeat.
4. Pull your legs up, tighten all the muscles of your legs, pull your toes towards your body. Hold for a count of 5. Relax. Repeat.

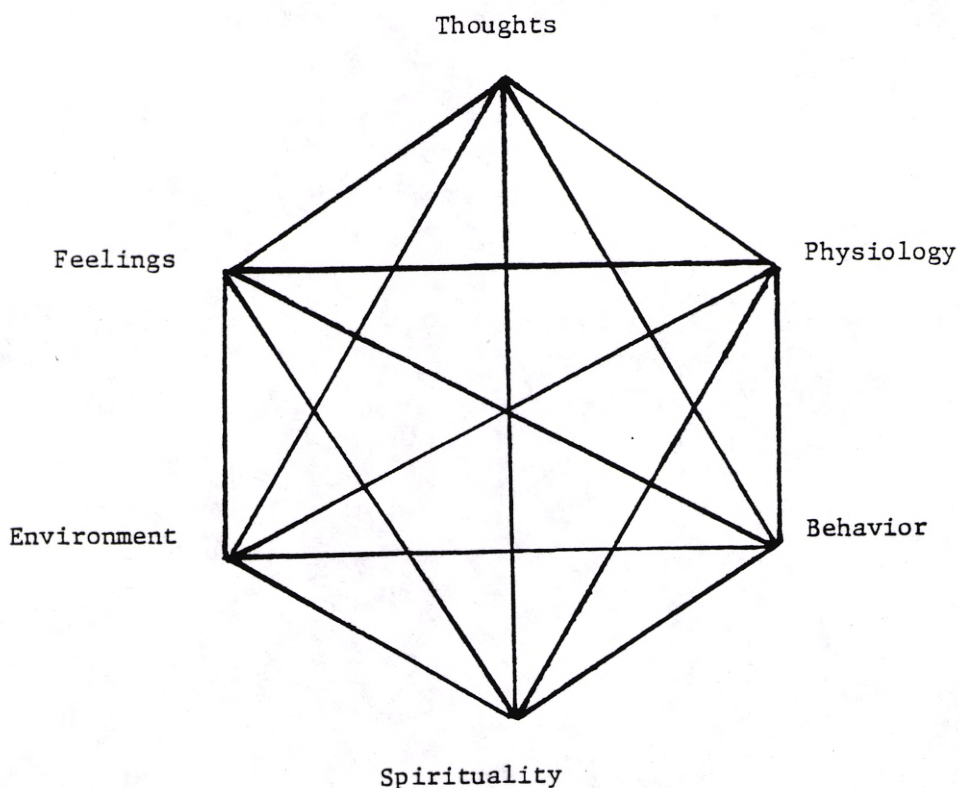
Hints:

1. You might want to make a tape of this exercise to listen to as you go through the relaxation. Be sure to leave enough time to hold your poses for a count of 5 and time to relax after holding.

MULTIDIMENSIONAL ASPECTS OF STRESS

STRESS - A perceived imbalance between demands
and resources available to meet those demands.

	INTERNAL	EXTERNAL
DEMANDS	Needs Expectations History/feelings	Others' needs Others' expectations Environment
RESOURCES	Attitude Skills (learned) Abilities (innate)	Social support Money "Equipment"



PROBLEM SOLVING

1. Identify the problem.
2. Make a plan.
3. Implement the plan.
4. Evaluate the plan.
5. If the plan has not been successful, start again at step 1.

Making a Plan: "The Seven A's"

1. ALTER - Change the situation.
2. ADAPT - Change something about yourself.
3. AVOID - Stay out of the situation, or stay away from the problem.
4. ALTERNATIVES - Look for other ways to view the problem, or other possibilities in the situation.
5. ALLOW FOR THE UNEXPECTED - Don't be too rigid about your expectations or how you approach the problem.
6. ACTION V. NON-ACTION - Decide carefully whether you need to do anything at the present time ("eastern" vs. "western" approach).
7. ACCEPTANCE - Accept that the situation exists (sometimes simply accepting something makes it less of a problem).

SIX TYPES OF THINKING

CONSTRUCTIVE vs. DESTRUCTIVE (involving thoughts about yourself, self-image, self-esteem, etc.)

Constructive thinking "puts you together".

Example: "I have the ability to change my life to get more of what I want."

Destructive thinking "tears you apart".

Example: "I am no good." "I can't do anything right."

NECESSARY vs. UNNECESSARY

Necessary thinking helps you do what you have to do.

Example: "I must remember to put gas in the car."

Unnecessary thinking doesn't change anything, no matter how much you think about it.

Example: "There is going to be an earthquake any day now."

POSITIVE vs. NEGATIVE (involving thoughts about people, places, things, events beyond yourself)

Positive thinking helps you feel better.

Example: "I am glad I have some good friendships that have helped me through some of the hard times these past few years."

Negative thinking makes you feel worse.

Example: "Everything in my life has changed for the worse, and I hate the way things are now."

Note: Destructive, unnecessary or negative thoughts are not necessarily untrue, nor is it a reasonable goal to never have such thoughts. By paying attention to the types of thinking you do use, however, you can change the emphasis so there is a more balanced quality of thinking and less unnecessary stress.

Adapted from the work of Ricardo Munoz, M.D.

University of California, San Francisco

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COMMON ERRORS OF THINKING

Exaggerating

Exaggerating problems and the possible harm they could cause, and underestimating one's ability to deal with them.

Overgeneralizing

Making a broad, general statement that emphasizes the negative, such as, "Nobody likes me." (Watch out for words like "always," "never" and "completely".)

Ignoring the positive

Being impressed by and remembering only negative events. For example, dwelling only on the people who did not come to your party, rather than being happy with those who came.

Pessimism

Believing that negative things are more likely to happen and that positive things are less likely to happen.

Blaming oneself

Thinking that negative things that happen are always and entirely one's fault.

Not giving oneself credit

Thinking that positive things that happen are always either just luck, or somebody else's doing, and never the result of one's own efforts.

These and other negative thoughts tend to be automatic -- and unreasonable -- but appear true or plausible when you are under a great deal of stress. The more uncritically they are accepted, the worse you feel.

Adapted from the work of Ricardo Munoz, M.D.
University of California, San Francisco
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WAYS TO CHANGE HARMFUL THOUGHTS

1. Priming: A way to get yourself to think about your good points.

To get a water pump going, you sometimes have to prime it by putting some water in from the top. When you start feeling down, sometimes it is hard to begin thinking positive things. You can write down a list of positive things about yourself and your life, put each thought on a 3 x 5 card, and take one card out at different times during the day to get used to remembering that you have nice qualities and that there are nice things in life. This technique helps to increase the number of positive thoughts you have during your day. After a few days, you can put some "wild cards" into your collection by including some blank cards. When you pull out a wild card, think of a new positive quality about your life or yourself. This will help you develop the ability to think positive thoughts without the use of cards. Eventually, you can train yourself to think positively without great effort or props, though it is always useful to keep a stack of cards on hand for difficult times.

2. Self-reward: Self-reinforcement.

One of the nicest things that people can do for us is to compliment us on things we do well. We like it when someone notices something we have accomplished that perhaps took a lot of effort. Hearing such rewarding words can help us feel better.

Since we often do things that no one notices, it can also help us feel better if we ourselves notice what we have done and give ourselves a pat on the back. Many people do not give themselves credit for the things they do. Many don't even notice how much they actually do during their day.

Mental self-rewards can be saying things to yourself like, "Well, that was a tough job, but I did it!" Or, "I am a good mother; I really care for my children." Or, "I am learning to get more control over my life."

3. Thought-interruption: Breaking disturbing chains of thought.

There are times when we get into a rut with a certain thought -- usually a negative one -- which keeps on bothering us throughout the day and makes us feel bad. It would be good to learn how to stop such thoughts from ruining our mood. There are a number of techniques that have been used: (1) One is to "yell" (in your mind) the word "STOP!", and focus on whatever else it is that you are doing. (2) Another is to tell yourself, "This thought is ruining my mood. Let's move on to another." (3) A third (especially good if it is a "necessary" thought that you have to do something about later) is to write it down and think about it later.

4. Worrying time: Limit setting.

There may be thoughts that are necessary ("Necessary thinking") and that you would not want to ignore altogether. On the other hand, thinking and thinking about a problem does not generally take care of it. This quality of insistent or obsessive thinking can use up all of your energy and attention so that you begin to do badly in other parts of your life. If you have a big problem at work, you might make your family miserable by worrying about it all the time at home. If you have a family problem, you might start doing badly at work because you don't concentrate on your work. Instead of having one problem, you can turn it into two (or even three if you start ruining your health).

One way to avoid this is to begin practicing "obsessive time" during which you will do nothing else but devote your entire attention to the problem that is bothering you. Choose a quiet place and a specific amount of time -- 10 minutes to 30 minutes a day is about as long as one can think of any problem productively anyway. Just consider the problem and try to come up with a solution. At every other time during the day, use "thought interruption" (see #3, above) to put off the obsessive thought until you can give it your full attention.

5. The Blow-Up technique: Utilizing humor.

This technique involves blowing a worry up out of proportion, using humor to minimize its impact. For example, if you are worrying about not being a good person, you might imagine your picture on the front page of the San Francisco Chronicle with the words "This is a bad person!" written next to it. The technique works best if you can exaggerate the worry so much that it becomes ridiculous and funny. If you can chuckle at your mental image, you have been successful at using it.

NOTE: Do not use this technique with worries that could become as bad as you imagine.

6. "The worst that could happen..."

This technique does not rely on humor. It involves merely thinking through the worst that will happen if your fears come true. For example, if you are really worried about meeting a certain deadline and your fear is getting in the way of your getting it done, thinking about the fact that the worst that will happen is that someone will be angry at you for some period of time may reduce your fear enough to let you work well.

7. Time projection

Sometimes when we get depressed, it seems that things are terrible and that they will always be terrible. There is a feeling that we are stuck behind a thick, heavy curtain which hides the future -- something we can never go through into a time better than the one we are in. It is helpful to break

through that curtain by imagining ourselves moving forward in time to a period when things will be better.

This is not "just kidding ourselves". Any one of us has had times in our past when we thought we wouldn't be able to make it, that we would never get over some hurt, pain or suffering, and yet we have all made it, we have all survived those bad times. Even if some pain remains around memories, the pain tends to get less with time.

8. The Pause: "Time out".

There are times when the best thing to do is to "hold everything" and let our thoughts and anxieties flow by without our actively engaging them. This is a kind of mini-meditation, in which you let your mind rest even for a few seconds, allow yourself to feel the experience of being relaxed, of being still, at peace, tranquil. This is particularly helpful when you are feeling hurried, having a hectic day, or feeling overwhelmed. Just knowing that you can feel at peace can sometimes give you some energy to face your day again.

9. Self-instructions

Talking to yourself isn't always crazy. We all do it. It can be like having a coach at your side, giving you directions. You can remind yourself to use these techniques. You can remind yourself of how you want to handle things.

Adapted from Ricardo Munoz, M.D.
University of California, San Francisco
Used with permission.

SETTING UP YOUR OWN STRESS MANAGEMENT PROGRAM -- A BEGINNING

All of us have our own stress management programs, though we may not think of things in quite these terms. We have a particular system we've developed through our lives which we use in dealing with stress. Some stress management techniques are more helpful than others. For example, dealing with stress by exercising regularly probably feels better than dealing with stress by developing tension headaches.

This worksheet helps you look at some aspects of your stress management program and assists you in considering changes you might want to make.

1. List the 3 areas in your life in which you feel the greatest amount of stress. These can be general or quite specific -- it's up to you.

A. _____
B. _____
C. _____

2. List the 3 areas in your life in which you find the greatest personal reward (because they are fun, fulfilling, exciting, give you a sense of accomplishment or meaning, or for any other reason).

D. _____
E. _____
F. _____

3. List the 5 activities in which you find the greatest relaxation.

G. _____
H. _____
I. _____
J. _____
K. _____

(Go to the next page.)

4. Prioritize your sources of stress (items A, B and C) in the following manners:

1. Most stressful _____

2. Medium stress _____

3. Least stressful _____

1. Easiest to change _____

2. Medium difficulty to change _____

3. Hardest to change _____

1. Most immediate concern _____

2. Medium concern _____

3. Most distant concern _____

5. Look at your areas of personal reward (items D, E and F) and compare them with your areas of stress (items A, B and C). Is there overlap? Does the overlap or lack of it seem significant in any way?

6. Prioritize your relaxing activities (items G, H, I, J and K) in the following manners:

1. Provides greatest relaxation _____

2. Second-greatest _____

3. Third _____

4. Fourth _____

5. Fifth _____

(Go to the next page.)

6. (Continued)

1. Most amount of time spent in this activity (about how much per week?):

2. Second most time (how much?): _____

3. Medium amount (how much?): _____

4. Second least time (how much?): _____

5. Least amount of time (how much?): _____

7. List your 3 stress areas (A, B and C), and then indicate which of your relaxing activities (G, H, I, J and K) seem to counter the stress in these areas:

1. The stress of A. _____ is affected by activities

_____.

2. The stress of B. _____ is affected by activities

_____.

3. The stress of C. _____ is affected by activities

_____.

Do you need more or different stress reduction techniques to deal with your areas of stress? If so, what do you think might be useful? Consider each of your areas of stress separately, then think about all of them together.

8. Looking over your worksheet, what changes would you like to make in your current stress management program?

What change(s) can you make this week?

GROUP EVALUATION

The thing I liked best about this group was _____

The thing I liked least about this group was _____

If I could change something about this group, it would be _____

My advice to the facilitator(s) on ways she/he/they might improve her/his/their work with groups like this in the future:

Other comments:

BACKGROUND ARTICLES AND MATERIALS

Contents:

- Schedule.
- Ground Rules for Group Members.
- Guidelines for Group Members.
- Worried Well/ARC - Theoretical Assumptions.
- Infection Precautions for People with AIDS
- Understanding ARC: The Broader Spectrum of
AIDS (Focus 1:3).
- Diagnosis/Treatment: A Working Definition
of ARC (Focus 1:3).
- Safe Sex Guidelines.

STRESS MANAGEMENT GROUP
Tuesdays, 7:00 - 9:00 p.m.
January 29 - March 19, 1985

AIDS Health Project
333 Valencia Street (near 14th Street)

Marcia Quackenbush, M.S.
626-6637

John Acevedo, M.S.W.
558-2507

Schedule

1. Introductions.
Definition of stress.
Stress and health.
2. Increasing your awareness of stress.
The physiology of stress.
Early Warning Systems (Multidimensional Aspects of Stress)
3. Change as a stressor.
Problem-solving.
AIDS-related stress.
4. Conscious sexuality.
5. Cognitive aspects of stress.
The stress of homophobia.
6. Setting up your own stress management program.
7. Social support networks.
8. Evaluating stress management plans.
Review and evaluations.
Good-byes.

GROUND RULES FOR GROUP MEMBERS

For the group to function best, there are certain agreements all members need to share. These are the Ground Rules for the group. Our Ground Rules are:

1. Be on time. The groups start promptly, and we have a great deal to cover. As a courtesy to others and a measure of your own commitment, make the effort and be here.
2. Make your commitment to the full eight weeks. Each week new material is presented, and the trust and usefulness of the group builds over time. If you miss a session, you will lose something valuable for yourself and also lose an opportunity to contribute to others here.
3. Call if you will be late or absent. This is important in any group, but is especially necessary in a group where people are talking about AIDS. When someone isn't at group and we don't know why he/she is gone, others may worry that he/she is seriously ill. Respect the others here by letting the facilitators know if you will have to miss a session or come in late.
4. Do not use drugs or alcohol the day of the group. In this group, we are looking at stress. You will get your clearest picture of your levels of stress when you examine them free of unnecessary substances. If you come to group drunk or high, you will be asked to leave. (With prescription drugs, you will need to evaluate for yourself whether they are necessary or not. We do not suggest you go against a doctor's recommendation.)
5. No violence. There are sometimes differences of opinion in the groups. We encourage discussion of differences, but obviously will not permit physical violence. We will also intervene if there is verbal abuse or violence.
6. Maintain confidentiality. The materials in the group can be shared with your friends, and in fact we encourage you to talk about the skills you learn here. What is shared personally between members stays in this room. It is not to be talked about elsewhere.

It is very important that these Ground Rules be followed by all members of the group. If there is anything that is unclear, be sure to ask. Remember, it is our expectation that all of us commit to these common agreements.

GUIDELINES FOR GROUP MEMBERS

The "Ground Rules" are mutual agreements all members make which are necessary for the group to function well. "Guidelines" are suggestions which outline the ways to get the most out of the group.

1. Participation is encouraged, but not forced. We may ask you at some point in the group how you feel about a topic that is being discussed. We are interested in your answer, but do not feel forced to reply. You can decline comment if you wish.
2. Trust increases with increased participation. One of the reasons we encourage you to participate is because, in our experience, those who are active in the exercises and discussion report the most benefits from the groups.
3. We will encourage communication between members. We have many important skills and concepts to teach here, but what is often more important is what group members have to say to one another.
4. We acknowledge individual differences. It is not our goal to have everyone in the group agree on everything. Acknowledging and accepting our differences is a very powerful and productive part of the group experience.
5. We will maintain structure in the group. Sometimes we will pull discussions back to the topic at hand, or finish up one topic so we can move on to the next. The material we have to share is important, and structure is the way we can share it.
6. You get back what you put in. If you are enthusiastic, open, committed to the group, it will be a valuable and worthwhile experience. If you are involved and energetic, the group will be productive for you. If you withhold your energy and enthusiasm, you will benefit less from the group. The choice is really up to you.

AIDS Health Project

Worried Well/ARC Program:

Theoretical Assumptions

By Peter Goldblum, Ph.D.

The Worried Well/ARC Program of the AIDS Health Project provides Educational Support groups to persons at risk for AIDS. These groups are designed to assist participants to better understand the nature of the epidemic and to develop new skills to cope with it.

The underlying theoretical assumptions and strategies for change used in the groups are derived from current public health and health psychology theory which emphasizes a systems view of health and health promotion (Dubos, 1966; Engel, 1977). According to this theory, disease is viewed as "multifactorial in origin, involving genetic, endocrine, nervous, immune and behavioral-emotional interrelationships" (Salk, 1962). Furthermore, health is seen as more than the absence of disease. The biopsychosocial model of health suggests that "health is the experience of well-being resulting from a dynamic balance that involves the physical and psychological aspects of the organism, as well as its interaction with the natural and social environment" (Capra, 1983).

Current medical understanding of the etiology of AIDS focuses on a viral attack on the immune system but to date, there is no vaccine and no sure medical treatment for the disease. Psychosocial intervention provides the only hope at this time to curb the spread of the epidemic. Recent developments in the field of psychoneuroimmunology have been incorporated in the development of the AIDS Health Project groups. According to this theory, AIDS, like other viral diseases, depends on two interrelated factors: an agent and a receptive host.

In the groups, participants are taught how to reduce their exposure to the virus while learning ways to strengthen their immune system. Groups encourage the reduction of exposure to the virus by promoting safe sexual practices and discouraging IV needle use. The second part of the health strategy focuses on strengthening a person's defenses against invasion by the virus (host factors) by emphasizing the reduced use of drugs and alcohol, development of new skills in stress management and depression prevention, intelligent approaches to proper nutrition, and appreciation of the need for positive social support in coping with the epidemic.

AIDS Health Project: Worried Well/ARC Program: Theoretical Assumptions

Special attention and care has been paid in developing groups to understand and be sensitive to cultural and political concerns of persons in the targeted high risk groups. In San Francisco, the primary consumer of services has been Gay men, a group which has experienced political oppression and is frequently suspicious of medical and psychiatric attempts to enforce sexual behavior change. Three assumptions relevant to the Gay community are made clear to participants upon entering a group.

Assumption 1: Gayness is a natural variant of human behavior.

Assumption 2: Sexuality is an important aspect of human experience.

Assumption 3: The pressures on gay men and lesbians from a hostile society place extra demands on them which can negatively affect their health.

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INFECTION PRECAUTIONS FOR PEOPLE WITH A.I.D.S.
LIVING IN THE COMMUNITY

Grace Lusby, MS, RN
Infection Control Coordinator, San Francisco General Hospital

Helen Schietinger, MA, RN
Director, Shanti AIDS Residence Program

San Francisco General Hospital Medical Special Care Unit and
San Francisco Bay Area Association for Practitioners of
Infection Control AIDS Resource Group

People with diagnosed AIDS who are able to care for themselves at home can safely live with both healthy individuals who do not have AIDS or with other persons with AIDS. Certain common sense hygienic measures protect both the person with AIDS as well as their housemates.

1. Care should be taken to not share body secretions, particularly blood or semen. In order for body secretions to be shared, there must be a point of entry into another person's body. Preventing this transfer of body secretions while still maintaining one's sexuality requires foresight and common sense. Risk reduction counseling for those who wish to remain sexually active is available through the San Francisco AIDS Foundation (San Francisco 864-4376) or Shanti Project (San Francisco 558-9644). This is important both to prevent possible transmission of AIDS to others and also to prevent acquiring other infections which may not be well tolerated by the person with AIDS.

There is no reason why persons with AIDS should not continue to have the usual casual social contacts with people that they have had in the past.

2. Maintaining a state of personal cleanliness is helpful to both the person with AIDS and others. This includes bathing regularly, washing hands after the use of bathroom facilities or contact with one's own body fluids such as semen, mucus, or blood, and washing hands before preparing food.
3. Kitchen and bathroom facilities may be shared with others. Normal sanitary practices in any household will prevent the growth of fungi and bacteria that may potentially cause illness to both immunocompromised and immunocompetent people. These include:
 - a. Clean kitchen counters with scouring powder to remove food particles. Sponges used to clean in the kitchen where food is prepared should NOT be the same sponges used to clean up bathroom-type spills. Dirty looking sponges should not be used to wash dishes or clean food preparation areas.
 - b. Clean inside of refrigerator with soap and water to control molds.
 - c. Mop kitchen floor at least once a week and clean up spills as they occur.
 - d. Mop bathroom floor at least weekly and clean up spills. Bleach, 1:10 strength (1 part to 9 parts water) can be used to disinfect floor and shower floor (athletes foot is caused by a fungus which bleach will kill). 1:10 bleach can also be used in the sink. A little full strength bleach can be poured into the toilet bowl for

disinfection. Any spills of body fluids or waste (blood, urine, stool, vomitus, etc.) should be cleaned up first and then the surface disinfected with 1:10 bleach.

- e. Sponges used to clean the floor or any body fluid spills SHOULD NOT BE USED TO WASH DISHES OR CLEAN FOOD PREPARATION AREAS. Mop water should NOT be poured down sink where food is prepared. Sponges used to clean up spills should not be washed out at sinks where food preparation occurs. Sponges and mops can be disinfected by soaking in 1:10 bleach for 5 minutes (longer may disintegrate sponge).

People with AIDS who are able to handle their own body secretions and excretions are able to live at home without any special precautions. Those listed above are considered good hygiene for any household.

4. Dishes may be shared with others provided they are washed in hot soapy water hot enough to require gloves. A disinfectant does not need to be used.
5. People with AIDS can safely cook for others provided they wash their hands before beginning. It's also a good idea to not lick the fingers or taste from the mixing spoon while cooking. (Advice for everyone)
6. Since unpasteurized milk and milk products have been associated with Salmonella infections in the past, these should not be included in the diet. Salmonella infections are not well tolerated by people with AIDS.
7. If organically grown food is used (composted with human or animal feces), food should be cooked or be fruits that can be peeled. 'Organic' lettuce is not safe.
8. Towels and wash cloths should not be shared without laundering in between people. Toothbrushes, razors, enema equipment and sexual toys should not be shared.
9. Trash disposal should be the same as for any household. Body wastes are flushed down the toilet. Other trash may be adequately handled by normal means (weekly trash pickups from cans lined with a plastic bag and a tight fitting lid to keep out rodents). In the even of large amounts of sputum, wound drainage, etc. on kleenex or dressings, it is a good idea to collect them in a lined trash can in the house.
10. Pets - gloves should be used when cleaning bird cages (Psittacosis) and cat litter boxes (Toxoplasmosis). Tropical fish tanks may contain organisms in the Mycobacterium family which are not well tolerated by persons with AIDS. Get someone else to clean your tank.
11. Keep living quarters well ventilated. Airborne diseases are less likely to be a problem when diluted by lots of air.
12. Persons with AIDS living together can do so safely by observing the same common sense hygiene practices discussed above. The opportunistic infections acquired by persons with AIDS are caused by organisms commonly found in the environment. The risk of becoming sick from one of these infections is based on the amount of immune system impairment, not of casual household contact.

Understanding ARC: The Broader Spectrum of AIDS

John Acevedo, MSW

Recent studies of people at risk for AIDS reveal several individuals who have conditions related to the immune disorder that are not included within the definition of AIDS itself. Physicians and researchers have yet to agree on a universal definition or name for these conditions, and much uncertainty exists for patients, caregivers, and service providers. The term AIDS Related Conditions or ARC has gained some prevalence as a working description of this spectrum of infections and conditions, but what constitutes ARC is not well-defined.

Many of the conditions referred to as ARC are as disabling as, or sometimes even more disabling than, those associated with some stages of AIDS. However, many people encounter great difficulty in qualifying for and receiving insurance coverage, disability benefits, and social services. Moreover, the uncertainties that arise from this confusion often exacerbate patient reactions.

The purpose of this report is (1) to help clarify for the mental health professional what is meant by a diagnosis of ARC, (2) to heighten awareness of the perspective of the ARC client, (3) to review successful clinical strategies in working with this population, and (4) to highlight issues raised while working with these clients.

A Variety of Descriptions

A brief historical review provides a perspective for understanding ARC. As early as the summer of 1981, physicians documented evidence of an acquired immune deficiency found initially in the male homosexual population. One gay newspaper popularized the term Gay Related Immuno-Deficiency (GRID) (1). However, once epidemiologists identified additional at-risk populations, such as I.V. drug users, hemophiliacs, and Haitians, the term Acquired Immune Deficiency Syndrome (AIDS) was established (2).

Important parallels exist between the evolution of the AIDS definition and the recent attempts to describe ARC. In 1981 Donald Abrams, MD, observed an increased incidence of diffuse lymphadenopathy (swelling of lymph glands) among gay men. He began a prospective and longitudinal study of the natural history of the condition in these men, many of whom were first seen and referred by community physicians. Abrams' work paralleled studies underway in New York City and Los Angeles.

In May 1982, the Centers for Disease Control (CDC) recognized persistent generalized lymphadenopathy as having epidemiologic similarities to those men who had Kaposi's sarcoma and *Pneumocystis carinii* pneumonia. These studies

indicated other accompanying clinical symptoms, including fatigue, fevers, night sweats, and unexplained weight loss. Abrams, now a researcher and assistant director of the AIDS clinic at San Francisco General Hospital, observed a broader range of symptoms among his lymphadenopathy patients. These symptoms included headaches, sinusitis, pharyngitis, thrush, diarrhea, perirectal complaints, and skin complaints, especially herpes simplex and herpes zoster, tinea, impetigo, and condylomata. In addition, Abrams and other physicians noted psychologic complaints of anxiety, depression, and reduced libido.

As the number of case reports of AIDS increased, the vast majority of patients gave histories of these non-specific symptoms. Many physicians suggested the symptoms were prodromal; that is, they believed the appearance of such markers would be followed by an AIDS diagnosis. However, labeling all such patients as having AIDS prodrome clearly carried prognostic implications for which there was little evidence. During this period, the term "pre-AIDS" was popularized by both the media and some members of the medical community. To clarify this issue, the concept of an AIDS-related complex was developed. Community groups use the generic term, AIDS-related conditions (ARC). This term provides the clinician with a global picture of any medical condition that indicates a suppressed immune system in a person at-risk for AIDS or with evidence of AIDS viral infection, that does not meet the case definition of AIDS, and that ranges in acuity from mild to severe.

"The identification of ARC patients may help prevent early complications and prolong survival, may enhance research, and may facilitate the provision of supportive therapies."

While ARC surveillance data has not been collected, health officials estimate that for every person with AIDS, there are ten persons with ARC (3). Although preliminary data from the studies of lymphadenopathy by Abrams and others suggests that 10 to 25% of diagnosed cases of ARC will progress to AIDS, the lack of a universal definition makes it difficult to compare their data.

The uncertainties about the ARC definition remain unresolved, and the need for mandatory reporting of ARC continues to be unaddressed. Accurate information is difficult to obtain due to concerns about confidentiality. Mortality rates of ARC patients are unknown at present, but anecdotal reports abound of deaths prior to formal AIDS diagnoses. The identification of ARC patients may help prevent early complications and prolong survival, may enhance research, and may facilitate the provision of supportive therapies.

continued on page 2

**AIDS
HEALTH
PROJECT**

A Publication of the AIDS Health Project, University of California San Francisco

FOCUS is a monthly publication of the AIDS Health Project, an organization concerned with AIDS Prevention and Health Promotion. Funded by a grant from the state Department of Health Services to the San Francisco Department of Public Health, FOCUS presents AIDS research information relevant to health care and service providers. The AIDS Health Project is affiliated with the University of California San Francisco and the Department of Public Health.

Editor: Michael Heiquist; Medical Adviser: Stephen Follansbee, MD; Administrative Assistant: Joseph Wilson.
Director, AIDS Health Project: James W. Dilley, MD.

Understanding ARC...

continued from cover

The current situation intensifies the complex psychological reactions to an ARC diagnosis by both client and practitioner. Given the current lack of information, the mental health care provider's initial reaction might be one of helplessness. However, my experience suggests that client reactions parallel those of other people facing terminal illness.

Role of Psychosocial Intervention

A thorough psychosocial assessment is essential for anyone who presents for treatment of psychological reactions to an ARC diagnosis. Practitioners must address pre-existing psychiatric disorders before attempting other interventions. In addition to standard medical and psychotherapy histories, a history of sexually transmitted diseases (STDs) helps to clarify at-risk status. The practitioner should also obtain a thorough history of substance use. Clients often present with confusion and ambivalence about their diagnoses; history-taking allows for client self-definition of illness.

The scope of psychological reactions reported in the literature on death and dying provides a valuable context for understanding the reactions of ARC clients. Shock, denial, fear, anger, sadness, depression, and bargaining are the norm for them. Interpersonal therapy techniques, such as supportive, insight, cognitive, and behavioral models help clients cope. In addition to using these approaches, practitioners need to take a more active, educational role. Referrals to appropriate resource agencies, to medical journals, and to individuals in the community are helpful to some clients. Providers who only present a blank therapeutic screen may exacerbate problems and alienate the client.

Cognitive-behavioral approaches have been effective in teaching specific skills and techniques to manage stress, depression, anger, and fear resulting from the uncertainty of the illness. These approaches are especially effective for addressing feelings of helplessness, alienation, and decreased or damaged self-esteem. They also provide structure and context to an otherwise chaotic experience.

Models for Empowerment

Mental health practitioners have used the following models to help ARC clients cope with their situations: (1) the continuum of withholding and disclosure, (2) personal and sexual identity, and (3) the impact of thoughts and feelings. These models apply to both individual and group settings. A brief description of each follows.

(1) **Withholding and Disclosure.** Withholding has two aspects: protection and denial. Clients may withhold information either to protect themselves or others, or to deny that a problem exists. Disclosure can lead to intimacy and trust, or it can bring about increased vulnerability. This model provides an understanding for conflicting feelings and reinforces clients' skills developed from previous disclosures. Clients are encouraged to discuss parallels between "coming out" as a sexual person and coming out as a person with ARC. Exploring this continuum often elicits other issues, such as independence and dependence, autonomy and merging, the real and the non-real.

(2) **Personal and Sexual Identity.** Personal identity and sexual identity are not static in relation to each other; rather they merge and dissociate at different times. Personal identity includes all of one's strengths and weaknesses. Conscious sexual identity is viewed on a developmental scale with changes from childhood to adulthood.

For many gay men, sexual identity has been limited to participating in sexual activities without exploring other dimensions related to being gay. The advent of AIDS and the necessity for sexual behavior changes confronted many men with an apparent identity crisis. This model acknowledges the experience of loss — death and loss of community members, loss of sexual activities, and the existential loss of identity — and encourages the client to become aware of deeper issues such as homophobia, love and lovers, death, and the meaning of life.

Problem-solving, behavior changes, and the development of new meanings are directions for the client to take when ready.

(3) **Impact of Thoughts on Feelings.** For our purposes, I have defined feelings as immediate emotional reactions, and thoughts as sentences people tell themselves. Negative, destructive, and unnecessary thoughts contribute to feeling out of control and to attitudes of hopelessness and helplessness. Cognitive techniques can be used to teach clients the skills needed to redirect thought patterns into more positive and constructive modes. These thoughts contribute to a sense of control, hope, and responsibility.

Implications for Providers

The practitioner working with an ARC client faces a number of counter-transference issues. The primary one is homophobia. Providers who retain even subtle biases against homosexuality are apt to harm clients by reinforcing negative self-concepts. Clinical supervision can help the provider explore personal attitudes toward a gay client's basic concept of self-worth and sense of power and control. Personal values about who is entitled to power in our society need to be addressed not only when working with gay clients, but also with blacks, addicts, and women.

Confronting death elicits major power and control concerns for the provider, and practitioners can expect to confront their own issues of loss. Acknowledging the powerful feelings of helplessness and the tendency to collude with ill clients is one approach to help keep separate the practitioner's feelings from the client's issues. Suicide raises ethical considerations; and providers may experience a range of reactions similar to those reported by their clients. Professional support groups, supervision, and individual therapy can help address these feelings.

In summary, the issues associated with ARC are multifaceted and complex. A thorough psychosocial assessment can provide the practitioner with the information necessary to help ARC clients. Pre-existing psychiatric disorders should also be addressed. Practitioners can employ both individual and group models to assist clients with their responses to ARC, for developing appropriate coping skills, and for changing at-risk behaviors. Providers should appreciate how different sexual identities, personalities, and ethnic and cultural influences may affect the individual response to ARC. The general goals of treatment include helping clients to recognize the control they can exercise over their lives; to develop strong, positive, and realistic senses of self; to deal with anger, anxiety, and loss; and to strengthen their support systems.

John Acevedo is a clinical social worker on the staff of the AIDS Health Project.

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Diagnosis/Treatment

A Working Definition of ARC

To define AIDS Related Conditions or ARC is no simple task. A complete definition for these symptoms and conditions has eluded us for nearly four years, and researchers see no sign that the confusion will end in the near future. Ultimately, surveillance guidelines and a medical description of ARC must be formalized by federal health officials. In the interim, both researchers and physicians in private practice seek to develop a working definition to help them interpret the results of clinical studies and to follow more accurately the course of these conditions.

To help the practicing clinician make better sense of the uncertainties surrounding the medical diagnosis of ARC, FOCUS

presents here the current thinking on the subject.

Last June at an AIDS symposium in San Francisco sponsored by the Bay Area Physicians for Human Rights (BAPHR), Dr. Michael Gottlieb of the UCLA School of Medicine proposed a new designation to replace the term ARC.

"If I had my way, the name would refer specifically to a virus-related condition," he commented. "Thus, we could speak of 'HTLV-3 disease' or 'LAV Related Condition.'"

Gottlieb suggested a number of problems with the current use of the term ARC. He said he believes physicians may over-diagnose ARC. For example, symptoms that clearly suggest syphilis may instead prompt a focus on AIDS. In addition, a diagnosis of ARC, according to Gottlieb, may lead to just as many abuses of civil liberties as the higher-profile AIDS diseases.

However, Gottlieb's approach does not resolve the problems resulting from the multiple names given to the AIDS virus. To use three alternate names to describe the AIDS viral disease may simply compound the difficulties. UC San Francisco researcher Jay Levy, MD suggests that the cumbersome "LAV/HTLV-3/ARV" designation can often be replaced by the more generic term "AIDS virus." However, to say someone has "AIDS virus disease" leads once again to associations with the current AIDS stigmas.

BAPHR Proposes Working Definition

Physicians in private practice who are on the front lines of patient care need an actual definition for the AIDS related conditions they see. Last December BAPHR announced the completion of a proposed definition of ARC. It assumes that other established causes of the listed abnormalities have previously been ruled out. It does not require the results of the AIDS antibody test. BAPHR suggests different groupings of clinical, immunologic, and other laboratory findings can constitute ARC (see accompanying table).

BAPHR suggests that different groupings of these findings can constitute ARC. The definition will be suggested to the Centers for Disease Control as a working guideline until that agency publishes its own. BAPHR promotes local use of the definition to facilitate communication among physicians and health care agencies.

Another approach to AIDS and ARC classification appeared last year as a result of discussions among federal researchers (1). Dr. Gottlieb worked with more than 80 AIDS investigators to develop a descriptive classification of AIDS virus related disease in patients willing to participate in clinical drug trials. The researchers suggested that all patients entered into clinical trials be members of AIDS-risk groups (gay men, IV drug abusers, hemophiliacs, heterosexual partners of a risk group member, blood transfusion recipients, and infants of a risk group member). All patients must have antibody to the AIDS virus, according to the researchers.

The informal task force proposed seven categories resulting from infection with the AIDS virus. The categories begin with an asymptomatic condition and are followed by lymphadenopathy and minor opportunistic infections and then AIDS with KS but without opportunistic infections. The final category represents a full-blown state of opportunistic infections with or without KS. The researchers do not propose these categories to define ARC or to suggest a progression from viral infection to CDC-defined AIDS.

The BAPHR definition addresses the social service needs as well as the clinical needs of people with ARC. The classifications by Gottlieb and associates only set standards for determining eligibility for various clinical drug trials. But the latter grouping also encompasses the full spectrum of outcomes from AIDS viral infection. At some point the advantages of each proposal will likely be accommodated into one accepted definition or classification system.

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A Proposed Definition of ARC

REQUIREMENTS: Clinical—Two major findings, or One major and Two or more minor findings, PLUS

Immunologic — One or more findings, PLUS

Other Laboratory — Two or more findings.

CLINICAL*

Major	Minor
Lymphadenopathy-nodes = or >1 cm. at 2 or more extra-inguinal sites for at least 6 months	Night sweats for 3 months or more
Oral thrush	Fatigue
Hairy Leukoplakia (white, corrugated oral lesions)	Pruritis (itching) for 1 month or more
Herpes zoster (shingles) under age 60	Extensive seborrheic dermatitis or eczema
Fever for 3 months or more	Refractory dermatophytosis (skin fungal infection not responsive to treatment)
Weight loss of 10% or more of body weight or 15 or more lbs.	Bullous impetigo (bacterial skin infection)
Central or peripheral neurologic deficit	Extensive molluscum contagiosum (skin infection, small blisters)
Diarrhea for 3 months or more	Unexplained persistent sinusitis (sinus infection)

*Most symptoms may be intermittent or continuous for the period and must occur in the absence of any identifiable cause.

IMMUNOLOGIC

- Helper T-cell count under 400/cubic mm.
- Helper/Suppressor ratio of less than 1.0
- Cutaneous anergy (negative to 3 or more common skin tests) (lack of response to antigens applied to the skin)

OTHER LABORATORY

HTLV-3 antibody positive	Thrombocytopenia (abnormal decrease in number of blood platelets) (<100,000/cubic mm.)
HTLV-3 virus culture positive	
Leukopenia (abnormal decrease of white blood corpuscles) (<4000/cubic mm.)	Serum globulins (proteins in the blood, associated with antibodies) 3.5 g/dl or >
Lymphopenia (deficiency of lymphocytes in the blood) (<1000/cubic mm.)	Sedimentation rate (a non-specific indicator of inflammation) 20 or >
Anemia (hematocrit 35 or <)	Serum cholesterol <135 mg

Individuals who want more information about the BAPHR definition can contact the organization at Box 14546, San Francisco, CA 94114 or call (415) 558-9353. Reprints of the Gottlieb classifications can be obtained from Dr. Harry W. Haverkos, Building 31, Room 7A49, National Institutes of Health, Bethesda, MD 20205.

SAFE SEX GUIDELINES*

-SAFE-

Massage, hugging.
Social (dry) kissing.
Body-to-body rubbing (frottage).
Touching your own genitals (masturbation).
Vibrators or other sex toys (use your own).
S/M activities that do not involve bruising or bleeding.
Voyeurism, exhibitionism, fantasy.
Touching other people's genitals (mutual masturbation).

-POSSIBLY SAFE-

Anal intercourse with condom.
Vaginal intercourse with condom.
Fellatio (sucking cock) with condom.
Cunnilingus (oral-vaginal contact) with latex barrier.
French (wet) kissing.
Analingus (oral-anal contact) with latex barrier.
Anal or vaginal penetration with hands or fingers using
disposable latex gloves or finger cots.
External urine contact (watersports).

-POSSIBLY UNSAFE-

Fellatio interruptus (sucking - stop before climax).
Cunnilingus without barrier.
Anal or vaginal penetration with hands or fingers without
barrier.

-UNSAFE-

Receptive anal or vaginal intercourse without condom.
Active anal or vaginal intercourse without condom.
Fisting (hand in vagina or anus).
Analingus without barrier.
Fellatio without condom.
Sharing vibrators or other sex toys.

*"Safe" guidelines are well-established, as are the risks of unprotected vaginal or anal intercourse. There is always some controversy about other categories and these guidelines may change in the future.

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