

An Introduction to  
**Sexuality Education:**  
A Handbook for  
**Child Welfare Providers**

## **Also by Karen Rayne, PhD, CSE**

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# **An Introduction to Sexuality Education: A Handbook for Child Welfare Providers**

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- our sexuality educator colleagues and mentors, who have taught us many things about how to do this work; and
- the observant, dedicated professionals around the world who show up for children and youth and teach them about sexuality.

All of you have played a critical role in bringing *An Introduction to Sexuality Education: A Handbook for Child Welfare Providers* into being. We are deeply indebted to you.

# A Letter from the Authors

Dear Reader,

Welcome to *An Introduction to Sexuality Education: A Handbook for Child Welfare Providers!* This handbook will introduce child welfare professionals and caregivers to the world of sexuality by providing the basic knowledge and skills needed to discuss sex and sexuality with youth.

## About the Collaboration

*An Introduction to Sexuality Education: A Handbook for Child Welfare Providers* is a collaborative piece of work; the authors have their own professional expertise and experiences.

Karen brings almost two decades of working with youth and adults in sexuality education spaces. Her most recent work involves authoring trade books and professional curricula and training sexuality educators around the world. In this handbook, Karen writes primarily about psychological, biological, and cultural information about sex and sexuality.

Amber has experience teaching trauma-informed sexuality education to youth in foster care. They currently work as a sex-positive therapist who teaches youth, adults, and organizations about sexuality and gender. In this handbook, Amber writes about methods to optimize lesson content and mindful modifications to use when considering relationship dynamics and trauma.

Monica brings over a decade of experience in practice, policy, and research related to youth in foster care. While working with expectant and parenting youth in foster care, she discovered that she needed more information and tools to guide her conversations with youth about sexuality and sexual health. In this handbook, Monica writes about trauma, child welfare, and how caregivers can engage with youth.

Because of the different lenses that Karen, Amber, and Monica bring to these topics, they each authored specific sections of this handbook. Monica wrote the majority of the introduction material, Karen focused on the section entitled “All About Sexuality,” and Amber wrote the guides for the handouts. You will come to know their voices and perspectives as you read.

## Make This Handbook Your Own

The resources provided in this guide can be used in individual, group, and psychoeducational therapeutic environments. All the resources, including handouts, can be tailored to work with youth of any age; however, the recommended age is 11 and up.

We hope that you will take *An Introduction to Sexuality Education: A Handbook for Child Welfare Providers* and make it your own. As all child welfare professionals and caregivers know, every child is different, so there is no single approach to introducing, discussing, or handling a topic, including sex and sexuality. The information in this handbook is meant to provide you with knowledge and ideas. How you incorporate sexuality education into your work will depend on your role in the child welfare system and the specific child you are working with.

We offer handouts with suggested introductions at the end of the book; however, we hope you will see these as merely a few approaches among many.

### **Referring to State Laws and Child Welfare Policies**

Since you are working with minors, it is critical that you familiarize yourself with laws and local policies that might impact your work. Please consult your state laws for guidelines on working with and speaking to minors, as well as reporting procedures concerning minors. Professionals also need to be aware of whether guardian consent is required for sexuality education and be familiar with state laws that guide what can and cannot be talked about in various settings. Even though the child welfare system itself is often a proxy for the caregiver or responsible adult for a child, laws and policies may dictate that consent be received from biological parents as well. We do not discuss any local, state, national, or international regulations in this handbook because they shift too frequently for this to remain a reliable resource. However, we have provided a section entitled “Policy Guide for Professionals and Caregivers.” This section prompts you to look for specific state laws and policies to guide your work.

Many thanks to each of you for your work. Bringing information and introspection about sexuality to youth makes the world a kinder, more inclusive, more compassionate place for all of us.

Sincerely,



Karen Rayne, PhD, CSE



Amber Borcyk, MSSW, LCSWA



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## Introduction

Child welfare providers include a variety of professional and non-professional roles that range from frontline child welfare workers to foster parents to direct care staff at residential treatment centers. Child welfare providers often serve as surrogate caregivers for children who have experienced complex trauma. However, because so many adults are involved in a child's life, adults often assume that someone else has had "the talk" with a child. The truth of the matter is that disproportionately higher rates of unplanned pregnancy and sexually transmitted infections (STIs) among children in the child welfare system suggest that they are not receiving appropriate, adequate information from anyone.

### **Yes, this is your responsibility**

Child welfare providers are often trained to identify and respond to trauma and the unique ways that trauma shows up in the lives of each individual child. While this is critical, it does little to prevent continuing and ongoing trauma through experiences like sexual victimization, sexual exploitation, sexually transmitted infections, and unwanted pregnancy. All of these examples, and more, can happen through lack of information about and support around sex and sexuality. Sexual "acting out" is one of the only instances in which child welfare providers really delve into sexuality, and at that point, the conversation is reactionary and focused on correcting behaviors rather than preventing them.

While many child welfare providers have training in trauma, child development, and caring for children who have experienced trauma, the subjects of sexual health, sex, and sexuality are often ignored. Omitting this huge element of being human, of cognitive and social development, and of emotional and physical health does a disservice to providers and youth alike. All child welfare providers will benefit from, at a minimum, a basic understanding of sexuality and sexual health to better support their youth. Whether you are working with a young child or a teenager, everyone has feelings, thoughts, and experiences about sexuality, so the topic is bound to come up. Being prepared to discuss the complexities of sexuality is key to being confident and effective as a positive and influential adult in a child's life. Many times it is our role to educate children to correct common misconceptions or misinformation about sex and sexuality. Topics should include anatomy and physiology, body image, gender identity, healthy communication, birth and pregnancy, sexual orientation, safer sex, STIs, and much more.

Child welfare providers may shy away from the topic of sex and sexuality for fear of saying the wrong thing, violating agency policies, appearing inappropriate, or out of their own discomfort with the topic. Or they may feel comfortable and confident, and be excited to have an additional tool in their wheelhouse. We contend that the conversation about sex and sexuality is the responsibility of child welfare providers. The reality is that discussions about sex and sexuality should happen throughout childhood. There is no single conversation, class, or curriculum that will teach children everything they need to know for a lifetime. Child welfare providers should engage in developmentally appropriate conversations with children throughout their time in the child welfare system. Children need conversations about sexuality and sexual health with many adults, on many occasions, and regarding many topics. Your role is an important piece of this continuum of conversations with all of the children you interact with.

## No, you do not need to be a sexual health expert

Just as many child welfare providers are not specifically trained as sex educators, many teachers, educators, facilitators, and others who are not trained as sex educators nevertheless teach about sex. This includes nurses, coaches, history teachers, therapists, counselors, parents, and sometimes even the random person who ends up in the right place at the right time (or the wrong time!).

For child welfare providers, bringing the education framework into your work requires staying up to date with information about sex, sexuality, and sexual health, and being impartial despite potential personal biases. Both of these things require time and attention, and both are fully possible without being an expert. Rather, the key is to use resources and experts extensively, to refrain from judgment, and to be open to your own and youths' questions.

Even though you may feel uncomfortable or unprepared to talk about sex and sexuality, we assure you that engaging in a nonjudgmental conversation is often enough. We provide you tools in this handbook to help you locate facts quickly, and we provide you with adaptable tools for working with youth individually or in groups. However, we also encourage you to be honest about the limits of your knowledge and to direct children and youth to other providers who have more knowledge of a particular topic. To accomplish this it is imperative that you are able to develop collaborative relationships with potential referral sources in a youth's community.

## What's included in the Handbook?

This handbook includes the following sections:

- **An Introduction:** You're already here! This section gives you a quick map of where to find various topics throughout the handbook.
- **Trauma-Informed Sexual Health Framework:** We have a very complicated narrative around sexual health in our society. This narrative is often negative and teaches children that sexuality is inherently bad, dangerous, risky, powerful, attractive, and many more things, all while bombarding them with problematic representations of gender and sexuality in the media. Children who have experienced trauma are potentially at a greater risk of further trauma from receiving inaccurate, negative, and biased information about sexual health. This section provides opportunities and strategies for shifting this narrative in order to better meet the needs of children receiving services through the child welfare system.
- **Self-Analysis for Professionals and Caregivers:** It is important for child welfare professionals to constantly and consistently analyze themselves and their beliefs. In this section, Monica provides one simple and easy way to practice self-analysis.
- **Sexuality and Child Development:** While child development is a relatively common (although not ubiquitous) topic of conversation and learning in child welfare settings, sexual development is not always included. This section outlines sexual development from infancy through adolescence.

- **Policy Guide for Professionals and Caregivers:** Understanding the laws associated with talking about sex and sexuality with youth in foster care is critical for adults, but it can be challenging given the ever-changing nature of laws and policies in different communities. This section will not be exhaustive, but it will provide you with an idea of what to look for when researching laws and policies in your own community.
- **All About Sexuality:** This section is a great place to continue your learning about sexuality. Of course, outlining everything there is to know about sexuality would require many volumes, but this section will highlight many of the topics that you are most likely to need to know about when working with youth in the foster care system. The topics are listed alphabetically.
- **Handouts:** Engaging handouts make content easier to learn. We have included 24 sexuality handouts designed or repurposed for use in a child welfare setting, along with a guide to using each handout in groups or one on one. Many of the handouts pair well with multiple sections in the book, and they can be used at various times throughout the course of your work with youth. The handouts are listed alphabetically.
- **References:** This gives credit to our sources and provides you with the opportunity to further explore this important subject.
- **Additional Resources:** Feel like you didn't get enough information in the "All About Sexuality" section? Looking for something that wasn't included at all? This is an annotated bibliography of the authors' favorite resources, including books, articles, websites, and organizations, so you can continue your research into the world of sexuality and sexual health.



# Trauma-Informed Sexual Health Framework

Children and teenagers sometimes have traumatic experiences concerning sex and sexuality, and these experiences may never be disclosed to anyone. While most children enter the child welfare system due to neglect, sexual trauma is often part of their histories. Even when a child has not personally experienced sexual trauma, witnessing unhealthy or violent relationships is a common experience. Given the potential history of exposure to trauma on multiple levels it is vitally important that those working with youth in the foster care system do so in a trauma-informed manner, particularly as it relates to sex and sexuality.

## Trauma Overview

Trauma is the reaction to any real or perceived event or stressor that threatens a person's well-being, safety, or life. Trauma is generally grouped into five categories:

- **Acute trauma:** Experiences that occur once, such as a natural disaster, rape, or car accident
- **Chronic trauma:** Experiences that occur over time, such as incest, exposure to domestic violence, war, or ongoing physical abuse
- **Developmental trauma:** Childhood experiences that adversely impact development, such as neglect, food insecurity, housing insecurity, lack of access to healthcare, changes in caregivers, or discrimination
- **Complex trauma:** Varied, multiple traumas usually inflicted by trusted caregivers
- **Multigenerational trauma:** Stress passed down to new generations through physical changes in genes, behaviors, and beliefs due to traumas such as slavery, holocaust, racism, etc.

An individual's response to trauma is unique to them and is influenced by their environment, their history of trauma, and the level of support they have; no two people will react the same way. However, there is growing evidence regarding the impact of trauma on the brain and body. We now know that trauma can actually change the way our brain functions and, ultimately, how we respond to the world around us. For young children, trauma experienced during key developmental periods can have profound developmental effects. This is not to say that trauma determines a person's future. In fact, the relationships that children and youth develop with caring adults are key to healing from trauma.

Basic knowledge of our brains is one of the keys to understanding trauma. While our knowledge of neuroscience is ever expanding, a simple explanation of our brains developed decades ago continues to be an easy foundation for explaining the brain to non-neuroscientists (MacLean, 1990). If we think about our brain as having three main parts, we can easily conceptualize how we process information.

1. The lowest level of the brain, often referred to as the reptilian brain, is the first to receive information from the outside world. This part of the brain is instinctual and keeps us alive by regulating our body temperature, hormones, breathing, and other basic functions.
2. The second level of the brain is called the mammalian brain. It is responsible for helping us understand whether incoming information signals danger or a threat to our safety, and it generates the “fight, fright, flee, or freeze” response.
3. The final level is our human brain, where our frontal cortex is located, which controls all our higher-level thinking. This is the last part of the brain to develop, and it continues to develop throughout childhood and adolescence and into early adulthood. As we react to the world around us, our frontal cortex helps us regulate our reactions to what is safe and unsafe.

The information we receive from the world around us is filtered through each level of our brain starting with our reptilian brain. That part of our brain instinctively knows to regulate our heart rate, release hormones, and to essentially do what is needed to keep us alive. Information then gets processed by our mammalian brain, which cues our feelings and emotions. Finally, as we develop our frontal cortex, we learn how to think about external stimuli more critically and regulate how we respond.

For example, let’s think about a toddler who has never been around a dog. The first reaction to having a strange dog run up to her would likely be an elevated heart rate; then the mammalian brain would kick in to tell her to be fearful and flee to a trusted adult. Her brain is making a connection that the strange dog is scary, but if the trusted adult starts to pet the dog and show that it is safe, that toddler may then develop a healthy response to strange dogs, where she is cautious but not fearful. Conversely, if the trusted adult screamed and ran, the future response of the child would likely be fearful.

Small doses of fear and stress, like the experience of encountering a strange dog, are normal, healthy parts of child development if we are in an environment with caregivers who help us respond and regulate our emotions. However, prolonged exposure to fear due to traumatic events negatively affects the development of a child’s stress response systems, such that in a moment of trauma, the third level of the brain that controls our cognitive and rational thinking shuts down, our body goes into survival mode, and more complex thinking is not possible.

When children are in a prolonged state of fear, that stress can impair learning and brain development. In most cases, the child’s physical development progresses normally, but cognitive development is delayed. Using a trauma-informed approach helps us understand and support a child who may be going through puberty but behaves more like a four-year-old when making decisions.

## **Sexual Violence**

Sexual violence occurs when a person forces or manipulates someone into unwanted sexual activity that violates a person’s boundaries and rights to give or deny consent. Terms describing sexual violence are often used interchangeably and tend to be based on legal definitions. For example, the term “sexual abuse” is most often used to refer to an adult harming a child through any number of sexual

acts including touching, watching sexual acts, or harassment. The FBI defines rape as “the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim” (Federal Bureau of Investigation Uniform Crime Reporting, n.d.). Often, a child (or adult) might think that because they were not raped in a technical sense, they have not experienced sexual violence. In reality, sexual violence is pervasive in our society. It is estimated that one in four girls and one in six boys will be sexually abused before the age of 18.

Sexual violence is underreported both as a crime and as a reason for entry into foster care. For example, a child may enter foster care due to parental substance use but also have an undisclosed history of sexual abuse. Our society attaches so much shame to topics related to sex that it may silence those children who need our help the most. Children may repress memories of abuse, feel guilty, or feel responsible for getting the perpetrator in trouble if they disclose something. As a result, a provider may never know that a child has experienced sexual violence. It is important to note that a provider does not need to know all the details of an abusive experience to provide support.

Youth in foster care are also at heightened risk of sexual violence in their ongoing and future relationships after leaving the foster care system, especially when their experience includes episodes of running away and homelessness.

## Trauma-Informed Sexual Health

In this handbook, we have provided tools for providers and professionals to use with youth. However, they should only be used within a framework of understanding how to address sexuality and sexual health from a trauma-informed perspective. Below we have outlined the Substance Abuse and Mental Health Services Administration’s six key principles of a trauma-informed approach and how to apply those to working with youth in foster care (SAMHSA’s Trauma and Justice Strategic Initiative, 2014; Faulkner & Scherger, 2016).

The first principle is **safety**. Interpersonal interactions with youth must occur in a safe setting. While the foster care environment is intended to be a safe setting, we cannot guarantee that a youth will experience the environment as safe enough to discuss issues related to sexual health immediately. To create the emotional safety necessary to open topics of sexuality and sexual health, we recommend the following four things:

- **Avoid using scare tactics when talking with youth.** It is ineffective and harmful to tell a youth to not have sex because pregnancy and disease are “bad.” Some of the youth in care have already been pregnant or had a sexually transmitted infection due to sexual abuse, so saying those things are bad might make them feel that they are bad.
- **Operate from a sex-positive perspective.** There is so much in our society that glamorizes sex and sexual violence. At the same time, adults tend to send a message to youth that sex is scary and bad. In reality, most humans will engage in sexual activity in their lives, and we hope that those experiences are mostly (or exclusively!) positive. We can promote sexual health, including

abstinence from sexual activity, by talking about sex in a positive way. One key phrase that can be used is “Sex can be a really great part of your life when you are ready for it and when you choose it.”

- **Use inclusive language.** Most of the time youth will hear language that reflects opposite-gender relationships. A high percentage of youth in foster care identify as LGBTQ+, so the youth you are working with may not relate to that. As a regular practice in your conversations with all youth, use language that includes words like “partner” rather than gender-specific terms.
- **Know who you are.** In the next section we provide a thorough self-assessment. Understanding your biases, values, and trauma cues is critical to providing youth a safe space to talk about sexuality and sexual health.

The second principle is **trustworthiness and transparency**. Part of creating that safe emotional space is making sure there is trust between you and the youth. If youth have experienced trauma, trust can be difficult. Likewise, trust is difficult to establish in foster care. When caregiving bonds are disrupted, real attachment to another adult may be difficult and takes time. Youth will understandably be distrustful that the providers in their lives care about their perspective and well-being. This is not something to take personally. Move forward in talking about sexual health by doing these four things:

- **Provide accurate information.** Youth need up-to-date and accurate medical information. If you cannot provide that information, find medical professionals, sexual health educators, or online tools to help get answers. If you don’t know the answer to a question, admit it, and work together with the youth to find the answer.
- **Be truthful.** Your values will guide how you approach conversations about sexual health. Values that place judgment on behaviors or outcomes can be particularly detrimental and cause a youth to avoid talking with you. A good conversation can highlight the range of opinions on a topic. For example, you could say, “Some people believe sex is best when you are in a committed relationship. Other people believe having multiple partners is a good thing. What do you think?”
- **Normalize behavior.** Youth will not talk to you about sexual health if they think they will be shamed or judged. Normalizing behaviors should start with young children. For toddlers, it is normal to explore their bodies, so rather than negating that behavior, label body parts accurately and explain privacy. For adolescents, it is normal to be curious about sexual activities, touching someone else’s body, having someone else touch their body, and giving and receiving pleasure. Be open to conversations about those topics and to using accurate words or phrases to refer to sexual activities.
- **Be clear about confidentiality.** Working with youth who have experienced trauma means there is a high likelihood that you will obtain information that has to be reported. Explain to youth that you are a mandated reporter and be sure that you are clear about what you have to report as child abuse, what you have to share with caseworkers, and what you can keep confidential.

The third principle is **peer support**. Trauma survivors may benefit from mutual self-help and being part of groups where others have similar lived experiences. Likewise, providers may need peer support to understand the best ways of working with youth. In foster care, it may be difficult for youth to find peer support that is consistent and healthy. However, providers can take some key actions:

- **Look for mentors who have survived trauma.** A slightly older mentor who has experienced foster care may be a good support person for a youth in care. For providers, talking with other caregivers and former foster youth can help provide insight into how to address issues.
- **Find and use discussion points.** It might be hard to find peer support for youth in foster care. However, there are experiences all around us that can be used for discussions. Books, movies, music, and social media all provide great conversation starters for discussing sexual health and helping youth connect their experiences to what others might have experienced.

The fourth principle is **collaboration and mutuality**. This principle is often the most difficult for adults to practice. Collaboration and mutuality means that we truly partner with youth while recognizing that we are not in control of their lives, that youth are experts at their own lives. We recognize that we have power as adults, but we do our best to set that aside when talking with youth about their sexual health. Survivors of trauma experience a loss of power and control, so giving youth power is critical when talking about their bodies and choices. Adults should do the following to try to engage with youth in a collaborative manner:

- **Listen more than you talk.** If you find you are doing all the talking in a conversation, stop. Youth should talk, and you should listen without interjecting with what you think is best. Although this may be hard to do, try to interject with more clarifying questions than statements.
- **Recognize that you have power.** No matter what, you cannot level the power differential because you have responsibilities as an adult to report abuse and other concerns. As stated before, you need to be honest about those responsibilities. Recognize that you are not a friend, and do not make promises that you cannot keep regarding confidential information. Do not use your authority or position of power to force a young person to talk with you. The experience will be counterproductive and will damage your relationship with that youth.
- **Your experiences are not their experiences.** What you experienced growing up is not the reality of youth today. It is always tempting to compare your experience to someone else's, but in a conversation about someone else's sexual health, you are not the expert.

The fifth principle is **empowerment, voice, and choice**. Empowerment, voice, and choice means that we focus on strengths while respecting each youth's capacity to make decisions that are right for them when equipped with accurate information. Sex education in America tends to focus on negatives. Rather than emphasizing possible negative consequences about sexual health, focus on empowering youth by doing the following four things:

- **Encourage youth to think about their future.** Have ongoing conversations about what youth want in life. Invite them to think about their current and future family life. For some youth, talking about the future may be new; not all families talk about the future and what that may hold, and many youth are focused on daily survival, so it may be hard for some to put thought into their future in an authentic way. Keep in mind that goals will shift, and avoid judging one goal as better than another. Encourage youth to be flexible as they are developing goals.
- **Encourage conversations with medical providers.** In this handbook, we have provided worksheets about talking with medical providers. Adults must equip youth with the skills to talk to doctors on their own so they can be active partners in their own health care. For a five-year-old, this might mean encouraging them to tell the doctor their symptoms and ask questions. For an adolescent, this might mean preparing a list of questions prior to a visit, helping the youth schedule the visit, and then letting the visit happen without a nonmedical adult present. If a youth leaves an appointment with more questions than answers, talk about how to get those questions answered.
- **Avoid what you may have been taught.** Some adults were raised by caregivers who provided short answers to complex topics, like “Just stay away from boys,” “Wait till you’re married,” or “Don’t end up like so and so.” These statements are laced with judgment and ignore the complex realities of young people’s lived experiences. Instead of using these types of statements, take a deep breath and engage in a real conversation.
- **Discuss consent and choice.** Because some youth in foster care are likely to have experienced trauma, including sexual violence, talking about consent and choice is key when talking about sexual health. It is critical to emphasize that consent has to be active; it is not about someone “not saying no.” Consent means someone actively agrees to an activity without feeling coerced and without being under the influence of drugs, alcohol, or emotional pressure. Discussions about consent also need to include information about how to react to a partner who does not consent. To avoid shaming youth who have experienced nonconsensual activity, some phrases to use include:
  - Sex can be a healthy thing when everyone consents or chooses to take part; other times it can be harmful if one person is forced to do something.
  - Sometimes people have sex because they feel pressured.
  - Sometimes people have sex in order to survive.
  - No matter how a person has experienced sex in the past, they have the potential to experience sex in a healthy and positive way.

The sixth principle is **understanding and honoring cultural, historical, and gender issues**. In working with youth in foster care, we have to acknowledge the impact of social and economic inequality. Much of the dialogue about youth sexual health focuses on preventing teen pregnancy. The targets of these campaigns are often girls and often young women of color. We also have to acknowledge that some youth enter foster care due to lack of acceptance of their gender identity or sexual orientation by their families. To truly honor the capacity of all youth, we have to move toward talking about sexual health and their potential as humans to thrive. Thus, there are two critical things providers can do:

- **Consider young people's choices within the context of their lived experiences.** We started this section by discussing the brain and how we process information from trauma. When we think about sexual behaviors of youth that confound us, we need to remember what we know about the brain and trauma. Some adults often pass judgment on youth for behaviors that stem from trauma. In some cases those behaviors were adaptive for youth to survive the actual trauma. For example, a 15-year-old girl who repeatedly enters into relationships with 30-year-old men may be repeating a pattern of abuse from her childhood. She may believe she is safer in these familiar relationships than in relationships with same-age peers.
- **Do not demean family.** Providers in foster care want to help, and often they spot patterns within families. Never use phrases like “Don’t you want to be better than your parents?” In most cases, youth have fond memories of their parents and love them. Demeaning their family will alienate you from the youth.

Integrating these six principles into your interactions with youth may lead to improved positive connection, personal growth, and increased likelihood that youth will be open to dialogue related to sexual health. Consider these principles the foundation of your interactions around sexuality and sexual health with young people.



## Self-Analysis for Professionals and Caregivers

To have meaningful and affirming conversations about sexuality with young people, professionals and caregivers should be aware of their own attitudes, values, and beliefs around sexuality. Our biases will impact the way we work with and treat youth. In the child welfare system, we have to be mindful that the children and youth we work with often come from different backgrounds than we do.

Many cultures, including those in the United States, teach incorrect, and sometimes harmful, concepts about sexuality. This includes information about sexual orientation, gender, ethnicity/race, relationships, education, age, ability, and family structure, just to name a few. We also send conflicting messages about sexuality. For example, caregivers may reinforce ideas about refraining from sexual intimacy as adolescents, but watch movies or television where adolescents engage in sex. Or we might talk about empowerment of all genders while reinforcing stereotypes about how a person of a certain gender should dress or act.

Working with youth in the child welfare system also means we may be working with youth who have experienced sexual trauma. Youth may have knowledge of sex that surpasses knowledge of other youth and of adults. Youth may “test” adults to see what is safe for them to talk about. If an adult responds with disgust or provides a value-laden response, youth will likely refrain from talking with that adult. Everyone working within the child welfare system needs to strive to engage with youth in a trauma-informed and nonjudgmental manner to encourage youth to seek information.

### Examining Your Values

All professionals and caregivers have the ability to look past our own biases, beliefs, and issues in order to support youth in knowledgeable and healthy ways. We are always growing as people, which means we have to *constantly* and *consistently* challenge our own thoughts and feelings so that they do not cloud the ways we respond to youth.

Some adults may never be comfortable with sexual questions—or answers. Often the discomfort is fueled by societal structures and personal biases surrounding the topic. Adults may have their own experiences of sexual violence and other traumas that have driven them to this work. Analyzing one’s own personal biases is not an inherently easy task. It should begin with asking oneself pointed questions concerning sexual topics.

For child welfare providers, we encourage you to think through the two exercises below. The first asks you to think about what you believe is appropriate at different ages. The second exercise asks you to explore your values about different topics. You may find it helpful to explore these activities with groups of peers doing the same or similar work.

#### ***Exercise 1: At what age?***

Read through the following statements. At which age do you think it is normal or okay for a person to engage in each behavior for the first time? Keep in mind that your answer can be “never.”

- Having their own social media accounts
- Having a crush on someone
- Holding hands with someone
- Romantically kissing someone of the same sex
- Romantically kissing someone of a different sex
- Being alone with a romantic partner
- Being in love
- Consenting to intercourse
- Having vaginal intercourse
- Having oral sex
- Having anal sex
- Looking at pictures of naked people
- Becoming a parent

Now ask yourself the following questions:

- After thinking about ages when you consider things to be normal, do those same ages apply to children and youth whom you work with versus children in your family? Why might there be a difference?
- Which behaviors did you think were never okay?
- For which behaviors did you answer that it “depends on the kid”?
- Which behaviors made you uncomfortable to think about?
- Think about a child who was forced to engage in these behaviors at an early age. What stigma might they feel?

### ***Exercise 2: Your beliefs***

Read through the following statements and determine whether you agree or disagree with each one. Some of the statements may be difficult, but providing a response for each has the potential to prepare you for discussing this information with youth you are working with.

- Sex is best in the context of marriage.
- Masturbation is a healthy and acceptable behavior for young adults.
- Condoms are a good option for pregnancy prevention for young adults.
- Teens and young adults should wait until they’re in love before they have sex.
- Anal sex is a normal sexual behavior.

- Past sexual trauma leads to unhealthy sexual behaviors.
- If someone catches an STD, it's their own fault.
- Adults know best when it comes to teens and sex.
- Teens who use or experiment with drugs are troubled or on the wrong path.
- Men need sex more than women.
- Anyone under the age of 18 should not be permitted to take hormones to change their gender/appearance.
- Anyone under the age of 18 should not be permitted to have same-sex relationships.

Now ask yourself the following questions:

- Which statements were hard for you to decide on?
- If you were working with a youth who was doing something you disagreed with, what might you need to do to help that youth feel comfortable talking with you?

## Examining Yourself

All of us have unique life experiences that shape our values and how we react to situations. While reading the chapter on sexuality development in childhood, think about your experiences in your childhood. Consider the following:

- In infancy and toddlerhood, who took care of you? Who taught you about your body and how to take care of it?
- When you were preschool age, what messages did you receive about your gender and how to behave?
- In middle childhood, how were you first introduced to ideas about sex? What messages did you receive about sex? What was explained to you about anatomy and puberty? About other people's anatomy and puberty? Who talked to you about sex?
- In adolescence, what characterized your relationships? How did you or didn't you develop intimate relationships?

Consider which experiences were good for you and which may still bother you. If you experienced any trauma during these periods, think through how that might impact how you approach youth in that developmental stage. Some of these questions may be uncomfortable for those who have experienced trauma. If these questions bring up uncomfortable feelings or memories, consider reaching out to a peer or a professional to work through any trauma you feel may lead to you experiencing trauma cues while doing this important work.

## **Challenge Yourself**

Understanding your values and life experiences can help you understand your feelings if a youth brings up a topic that makes you uncomfortable. We encourage you to think about your values and life experiences and explore why you are uncomfortable. All of us have had, or will have, to face a time where our personal beliefs and biases are in opposition with a youth we are working with. We need to be prepared to manage any discomfort we may experience in a neutral trauma-informed manner when a youth's values conflict with our own, or when a youth hasn't determined what their own values are yet. By understanding yourself, you can avoid shaming around sexuality. Shaming can be re-traumatizing for youth who have experienced trauma, as well as damaging to the self-esteem of youth who have not.

## Sexuality and Child Development

As professionals and caretakers, we have theories and frameworks that guide our care of children to help them become healthy adults. Countless psychologists have taught us about the many facets of the cognitive, emotional, moral, social, and spiritual development of children. Multiple medical professionals have documented the physical growth of humans. However, there are minimal theories and frameworks regarding sexuality development in children.

Development of sexuality, identity, and sexual health has traditionally been talked about as a function of adolescence, where it is paradoxically viewed as both common and problematic. In the United States, sexuality of adolescents is most often discussed in reference to sex education in schools with the goal being to reduce or eliminate negative health outcomes. Likewise, research in this area has focused extensively on what works at reducing teen pregnancy and sexually transmitted infections. Very little research has focused on normative sexuality development of adolescents or younger children.

The development of a human's sexuality begins in infancy and progresses along with all other developmental processes such as cognition, social and emotional growth, and moral development. Because of the ongoing and progressive nature of sexual development, we have to be prepared to have ongoing conversations with children and adolescents about sexuality and sexual health. In our work, we generally find that adults who work with children are concerned about:

- Not knowing whether behavior is typical or a sign that a child has been abused
- Lack of confidence in the ability to say the right thing
- Fear of getting in trouble

In this section, we address the first two items to help you have a better understanding of sexuality development throughout childhood and adolescence. (The third item is addressed in a later section.) We will also provide some specific examples of how to explain concepts so you can practice and develop your confidence. We recommend that you practice reading and delivering the information so that when you have the opportunity to provide this information to a youth, you are comfortable and able to present it in a manner that is authentic to you.

### Child Development

The easiest way to understand child development is chronologically and linearly, but we have to be cautious in what we think about as "normal." For example, we see babies roll over, then they sit, crawl, and walk. While that progression is very typical, some babies never really crawl. They scoot and then just start walking. Those babies are typical as well. In thinking about any aspect of child development, we have to be cautious with the word "normal" because each person will progress through the stages of child development in a wide range of ways. While we will present information from infancy progressing through adolescence, keep in mind that some developmental tasks are more circular than linear. This may be particularly true for a child who has experienced trauma or a child with special needs.

## Child Development

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### Infants

When we talk about sexuality development in infancy, we are referring to the ability of a human being to develop trust, connection, and attachment to another person. This ability to form relationships is a foundation for multiple components of human development, including sexuality.

#### ***Key issues related to sexuality development***

From a psychosocial perspective, caretakers keep the infant’s body clean, healthy, and free from injury, which helps provide a foundation for the infant developing a positive self-image. Babies discover their bodies as they progress through their first year of life and gain control over their hands. A baby with a healthy sense of their body is going to be fascinated by their hands, feet, genitals, and anus. It is typical to have a baby touch themselves when a diaper is taken off. Aside from cleanliness issues, this is not a concerning behavior. Caretakers do not need to react to the behavior other than to continue diapering and then washing the infant’s hands. Caregivers can label the child’s body part just as they would the child’s eyes, nose, and ears. Caregivers can explain that we keep that part of the body clean: “That is your penis, we keep this part of your body clean. I am going to put your diaper on now.” Even if the infant cannot understand your words, you are helping yourself get comfortable with labeling body parts and explaining care.

#### ***When to be concerned***

With infants, there are only external signs that might indicate that a child has experienced sexual trauma. Pediatricians and mental health professionals should be consulted to discuss concerning conditions related to trauma. Unfortunately, many people believe that babies who experience adversity or trauma won’t be able to remember it and therefore will be fine. This is not the case; while babies who do not attach or experience severe trauma may not remember consciously, their behaviors demonstrate lack of trust in the world around them, sometimes for the rest of their lives.

| Expected infant behaviors                                                                                | Behaviors/conditions that may cause concern                                                                                                                     | Behaviors that should cause concern and might warrant intervention                                                                                  |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Touching their own genitals, anus when diaper is off</li> </ul> | <ul style="list-style-type: none"> <li>• Rarely smiling or responding to affection</li> <li>• Severe diaper rash</li> <li>• Urinary tract infections</li> </ul> | <ul style="list-style-type: none"> <li>• Bruises or bleeding around genitals or anus</li> <li>• Never smiling or responding to affection</li> </ul> |

## Toddlers

Toddlerhood generally refers to ages one to two years old. Although it is a short time frame, rapid changes occur. As with infants, sexuality development in toddlerhood is directly related to the biopsychosocial development that occurs during this time period. Toddlerhood is an important time in sexuality development because toddlers have major milestones in toilet training and language development. These milestones provide an opportunity for caregivers to reinforce positive messages about the child's body that they began in infancy while also teaching about the concept of privacy and boundaries.

### ***Key issues related to sexuality development***

When a toddler is toilet training, they become more interested in their own bodies and the bodies of others. Adults may be tempted to respond to their own discomfort by using cute names for body parts. It is important that caregivers label body parts with accurate language. When children know what to call parts of their bodies, they are better able to communicate with caregivers and medical providers when there is a problem.

Labeling body parts also helps teach about the concept of privacy and boundaries. These concepts can be introduced with toddlers, and should be reinforced later with preschoolers. Once body parts have been labeled, caregivers need to send a clear, age-appropriate message about what is private and what private means.

Toddlers show affection for their caregivers and their friends. They may hug or kiss to greet or say goodbye to others. This affection is a typical part of their development that is modeled and encouraged by caregivers. However, caregivers should start to teach about personal space, who it is okay to show affection to, and how to respond if someone does not want their affection. These early lessons help lay a foundation for understanding consent.

Toddlers should also be introduced to the idea of soft touches. They should be directed to use soft touches with their own bodies and when showing affection. Caregivers should keep in mind that a toddler is egocentric and will not understand another person's perspective or another person's feelings of hurt or pain. However, these boundaries are critical to introduce and reinforce.

| Expected toddler behaviors                                       | Possible caregiver responses                                                                                                                                                                                                                                                                                |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Child is exploring their own genitals                            | <p>"That part of your body is called a (vulva/penis/anus). Your (vulva/penis/anus) can get hurt easily, so you need to be gentle with it."</p> <p>"Sometimes it might feel good to touch your (vulva/penis/anus), and that is something you can do in private, like in the bath or alone in your room."</p> |
| Child is staring at another person using the restroom            | <p>"Going potty is a private thing. We are going to leave them alone."</p>                                                                                                                                                                                                                                  |
| Child touches another person's genitals or breasts               | <p>"This is my body, and I don't want to be touched there."</p>                                                                                                                                                                                                                                             |
| Child gives inappropriate hugs or gets in another person's space | <p>"Thank you for wanting to give (me/person's name) a hug. Remember to ask before you give hugs, because some people might not want a hug."</p> <p>"It's very nice to want to give hugs, but when we see grown-ups we don't know, you need to check with (caregiver) to make sure hugs are okay."</p>      |

### ***When to be concerned***

Toddlers are still developing language and cannot be relied on to provide accurate information about someone harming them. Adults tend to look for behaviors to signal that something is not okay. However, the line between concerning behaviors and typical behaviors is difficult to ascertain. Caregivers should seek the advice of their pediatrician if they have concerns about any behaviors. Below is a list of some examples of expected behaviors and behaviors that may cause concern.

| Expected toddler behaviors                                                                                                                                                                                                                                               | Behaviors that may cause concern, but probably just need redirection                                                                                                                                                                                                                 | Behaviors that should cause concern and might warrant intervention                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Showing their genitals to others, especially during toilet training</li> <li>• Talking about genitals with peers</li> <li>• Touching their own genitals</li> <li>• Taking off clothes, little inhibition with nudity</li> </ul> | <ul style="list-style-type: none"> <li>• Compulsive masturbation</li> <li>• Mutual masturbation</li> <li>• Play that involves aggressive sexual themes</li> <li>• Pulling or touching another child's or an adult's breasts or genitals</li> <li>• Simulating intercourse</li> </ul> | <ul style="list-style-type: none"> <li>• Forcing other children to touch or be touched</li> <li>• Genital injury or bleeding</li> <li>• Penetration of dolls, children, or animals</li> <li>• Verbal threats related to sex</li> </ul> |

## Preschool

Preschool age generally refers to children between the ages of three and five. During this age range children continue to exert power over their environment, but they gradually become less egocentric as they begin to engage in cooperative and imaginative play with peers. In terms of sexuality development, factual information, relationships, and gender roles are the focus of this developmental period.

### ***Key issues related to sexuality development***

Collaborative and imaginative play provides an opportunity for adults to teach and reinforce ideas about how to interact with others. A key idea that will emerge in children's play is gender roles. It is likely that preschoolers understand that some people have a penis and others have a vagina. While every family and child is different, children will likely associate a penis with boys and a vagina with girls. They also begin to assign ideas, tasks, and roles to people by gender, and this is often expressed in their play. Because children at this age overgeneralize rules, they may be very rigid in how they view gender. Some common examples may be children believing that all girls wear dresses, all boys play sports, or all families have a mom and a dad. It is important for caregivers to reinforce diversity in gender roles, and opportunities to do so will naturally emerge when being included in imaginary play.

Affection during imaginary play provides an opportunity for adults to help reinforce boundaries. Preschoolers may show affection through hugging and kissing friends. They may also talk about marrying a friend, parent, or other family member as a way to show affection toward that person. Learning that affection is a good feeling is important, and adults can help guide children in how to show affection in appropriate ways. For example, adults should direct children to ask to give a hug, particularly to those outside the child's family.

Preschoolers are busy gathering information about the world. They speak and ask questions in a very matter-of-fact manner about body parts or the act of sex. A common example would be a preschooler repeating explicit song lyrics or asking what they mean. Because preschoolers don't have the knowledge that adults have, they are not going to understand what is appropriate to discuss in different settings. Adults should answer questions and be very clear about when, where, and with whom topics should be discussed.

| Expected preschooler behaviors                                                  | Possible caregiver responses                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Child is hugging or kissing a friend, and friend does not want to be touched    | <p>"You want to show them that you like them. That is so nice. But it is their body, so we have to ask before we hug. If they say no, that is okay. They are still your friend."</p> <p>"If you don't want to be hugged, that is okay. Say 'no hugs' and let me know if they don't stop."</p>                                   |
| Child is upset in imaginative play because "family" is different from their own | <p>"All families are different. What makes a family is that they are people who care about each other and grown-ups take care of children. Tell me about your family."</p> <p>Engage in discussions about families: "In my family, we..." "In my neighbor's family, they..." "What do you do in your family?"</p>               |
| Child masturbates                                                               | <p>"Sometimes when you touch your (body part), it feels good, and that is okay. But since that is a private area, we don't touch ourselves there unless it is in private. And we have to be sure to use soft touches."</p>                                                                                                      |
| Child asks random questions about sex, reproduction, anatomy                    | <p>Answer what is asked. At this age, there is not a deeper meaning to what children are asking. If they ask how babies are made, just answer the question without going into complexities about relationships, etc.</p> <p>"Babies are made when a sperm meets with an egg. That makes the egg start to grow into a baby."</p> |

### ***When to be concerned***

Preschoolers may touch their penis or vagina as part of a natural way of exploring their bodies. They might also try to touch their friends or parents. These actions, while uncomfortable for adults, are not an indication of abuse necessarily. Rather, they may just be teaching moments and signals for grown-ups to talk with youth.

Other issues mistaken for abuse might include bedwetting or regression to less age-appropriate behaviors. Bedwetting can be an ongoing problem for preschoolers and is not by itself an indication of abuse. Other regressive behaviors may be caused by a number of factors such as placement into

foster care, moves, new babies, etc. In general, any change in behavior should be examined within the broader context of the child's life.

| Expected preschooler behaviors                                                                                                                                                                                                   | Behaviors that may cause concern, but probably just need redirection                                                                                                                                                                                                                | Behaviors that should cause concern and might warrant intervention                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Affection to peers</li> <li>• Imaginative play that involves themes of reproduction</li> <li>• Touching their own genitals</li> <li>• Watching others get dressed, undressed</li> </ul> | <ul style="list-style-type: none"> <li>• Themes of aggression during imaginative play relating to affection</li> <li>• Trying to expose others' private areas</li> <li>• Sexually explicit conversations</li> <li>• Preoccupation with masturbation, mutual masturbation</li> </ul> | <ul style="list-style-type: none"> <li>• Forcing other children to touch or be touched</li> <li>• Genital injury or bleeding</li> <li>• Masturbation that includes penetration</li> <li>• Penetration of dolls, children, or animals</li> <li>• Pretend play of intercourse with clothes removed</li> </ul> |

## Middle Childhood

Middle childhood ranges from about age six to age eleven. Although middle childhood is sometimes seen as a latent period in childhood, growth during this time period is critical. In terms of sexuality development, adrenal glands begin producing sex hormones.

### ***Key issues related to sexuality development***

During middle childhood, usually between six and eight years of age, adrenal glands begin to secrete estrogen and testosterone hormones. Adults may observe more division in peer groups based on gender. Children may act in a more "gendered" manner based on what they feel people of their gender should or should not do. Because children at this age want to fit in somewhere, they tend to follow the gender norms reinforced by their peers, family, and faith communities. Adults should introduce the idea of gender fluidity and encourage children to treat all peers with respect. Children who do not conform to rigid gender roles are more likely to experience bullying in schools. Caregivers should watch for signs of bullying and actively engage children in conversations about how peers are treated.

The concepts of sex and reproduction should be introduced to children prior to entering school. At this point in their lives, most children are exposed to the ideas of relationships, touching, and kissing by the media, friends, siblings, and others in their expanding social group. It is critical that caregivers provide correct, factual information about reproduction, sex, puberty, and anatomy. When discussing these topics with children who are not their own, caregivers should differentiate between factual information and information related to values.

Children at this age may use slang words, “potty humor,” or jokes to describe body parts and functions. Caregivers will need to provide redirection to ensure behavior and language is appropriate for the setting.

Another behavior that may begin in middle childhood is some form of admiration of idols. An idol can be someone in popular media or someone in the child’s life, like a teacher or friend’s sibling. Children may daydream about this idol, which helps them conceptualize ideas about love, emotions, and affection.

Social media and the internet may introduce children to new information and opportunities that require supervision. Caregivers should set clear rules about social media use while also explaining why those rules are in place. Children need to understand that material online may not be real and may be harmful. If children have unsupervised social media and internet access, caregivers should explain how and why children are coerced by predators online.

| Expected middle childhood behaviors                                                       | Possible caregiver responses                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Child asks about sex or it is clear that the child does not know and needs an explanation | <p>“Sex is something that can happen in different ways. It usually means bodies are close together and people are kissing each other because it feels good.”</p> <p>“Sex is a little hard to explain, and we will keep talking about it to make sure you understand. It’s okay to ask me questions.”</p> <p>To help explain concepts you are uncomfortable with or do not feel knowledgeable about, use books or tools in this workbook to help you.</p> |
| Child has developed breast buds                                                           | Do not assume that anyone has discussed menstruation with the child. Ask the child if they know about menstruation/periods and explain. Because children in foster care move around so much, purchase pads for the child so that they have them when they do get their first period.                                                                                                                                                                     |
| Child expresses affection for or idolizes a person of the same gender                     | Caregivers should normalize the feelings.<br>“Everyone likes different things about different people.”                                                                                                                                                                                                                                                                                                                                                   |

| Expected middle childhood behaviors                         | Possible caregiver responses                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Caregiver finds child searching for “boobs” on the internet | <p>Do not shame or scare the child.</p> <p>“I saw that you were searching about breasts on the internet. Did you have specific questions?”</p> <p>“I see that you are searching for pictures because you are curious. Looking for pictures of breasts online is not okay because many of the pictures are not realistic, and are sometimes even violent.” Offer an age appropriate book about bodies. Examples can be found in the Additional Resources section of this handbook.</p> |
| Child expresses that they are a different gender            | <p>“Thanks for sharing that with me. I think you are wonderful.”</p> <p>“Sometimes people are called (girls/boys) and they don’t feel like a (girl/boy). It is fine to be who you are.”</p> <p>Because of the high rate of victimization and suicide in this population, be sure to check in with the child about how they are feeling in school and with peers. If possible, connect the child to positive books and peer groups in their community.</p>                             |

### ***When to be concerned***

In middle childhood, masturbation is a typical activity. However, children should understand privacy and should be given privacy. Viewing pornography or looking at others naked may also be a typical behavior, but caregivers should address this behavior by discussing how pornography is not really how most people have sex, how bodies in the media are not always realistic, and how violence is not okay.

Major concerns during this phase relate to any indications of sexually violent behavior or behaviors that violate the boundaries of others. Children who have experienced sexual violence may have unclear boundaries with themselves and others, so caregivers will need to help set those boundaries. In some cases, children who have experienced sexual violence have age-inappropriate language and knowledge of sex that surpasses that of their caregivers. They may also be preoccupied by discussions about sex. Caregivers can build trust with youth during this age by consistently listening and calmly redirecting behaviors and language. When a concern continues, caregivers should ask for help from their pediatrician or a mental health professional to discuss specific strategies for that child.

| Expected middle childhood behaviors                                                                                                                                  | Behaviors that may cause concern, but probably just need redirection                                                                                                                                                                                         | Behaviors that should cause concern and might warrant intervention                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Daydreaming about idols</li> <li>• Explicit conversations or jokes with peers</li> <li>• Masturbation in private</li> </ul> | <ul style="list-style-type: none"> <li>• Attempting to see, film, or photograph others naked or exposing themselves</li> <li>• Compulsive masturbation</li> <li>• Explicit conversations with younger children</li> <li>• Interest in pornography</li> </ul> | <ul style="list-style-type: none"> <li>• Aggression, violating others' boundaries, bullying, harassment</li> <li>• Masturbation with penetration of self, others, dolls, etc.</li> </ul> |

## Adolescence

Adolescence ranges from ages 12 to 18 years, but may extend to age 21 depending on the individual. This time period is most often the focus of sex education and sexual development. However, the foundation for healthy development is built in earlier life stages. For children involved in the child welfare system, it is likely that there are gaps or trauma in their early development that will impact their adolescence.

### ***Key issues related to sexuality development***

Puberty is the key development during adolescence. For a description of changes during puberty, see the “All About Sexuality” chapter. As puberty begins, an increased need for privacy and independence is often expressed. Caregivers should provide ongoing information about the physical aspects of puberty and changes in the body. They should also educate children on the social and emotional aspects of puberty and help to normalize the new emotions and needs that they may be experiencing.

Caregivers also need to ensure that youth have access to accurate and factual information about sex, contraception, and sexually transmitted infections. However, this should not be done using shame or fear as a motivating factor. If caregivers do not have factual information, they should help youth find factual information through medical providers. Youth should be encouraged to have discussions with their medical providers and take responsibility for their own health.

To help guide youth into healthy relationships, caregivers should encourage critical thinking and build the skills to differentiate fact from fiction in media images and representations of sexuality. Caregivers should support youth in understanding they have both rights and responsibilities in their friendships and relationships. Discuss characteristics of healthy intimate relationships by discussing consent and mutual pleasure. Caregivers should also discuss parenting, the timing of parenthood, and future goals.

| Expected adolescent behaviors                             | Possible caregiver responses                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A new youth asks questions about their personal sex life. | <p>"I think adults can be nervous because they aren't sure how to explain things like sex. Honestly, I am nervous that I will say the wrong thing, but I want to make sure you have all the information you need."</p> <p>"When do you think it would be the right time for you to become a parent?"</p>                                                                          |
| Youth is talking about a movie, show, or song             | <p>Use popular media as a way to engage in conversations.</p> <p>"I love the beat of that song, but then I really listened to the lyrics. It makes me uncomfortable when people talk about hitting women. What do you think?"</p> <p>"Remember in that movie where she changed her whole personality just to be in a relationship? Have you ever seen someone act like that?"</p> |

### ***When to be concerned***

Adolescents who have experienced sexual trauma may display a range of concerning behaviors. Youth will have blurred boundaries and may not be able to pick up on red flags for abusive relationships. In some cases, adolescents may seek to establish control in their relationships by choosing to engage in relationships that mirror the abuse they experienced; for example, pursuing a person who is 20 years older than they are. They may also develop eating disturbances as a way to control their bodies or to simply become undesirable to others. Intimate relationships may be characterized by a lack of mutuality where the adolescent acts to pleasure others but not themselves. Adolescents may also engage in self-destructive behaviors and acts of self-abuse, such as cutting, as a means of relieving stress and anxiety, or as a trauma response.

Caregivers should keep in mind that adolescents often do not disclose past histories of sexual trauma. Caregivers do not need to know the details of abuse to provide support and guidance about healthy relationships.

| Expected adolescent behaviors                                                                                                           | Behaviors that may cause concern, but probably just need redirection                                                                              | Behaviors that should cause concern and might warrant intervention                                                                                                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Flirting, interest in potential partners</li><li>• Masturbation</li><li>• Intercourse</li></ul> | <ul style="list-style-type: none"><li>• Interest in pornography, erotica</li><li>• Sexual preoccupation that inhibits daily functioning</li></ul> | <ul style="list-style-type: none"><li>• Aggression, force</li><li>• Disordered eating</li><li>• Relationships with large age differences</li><li>• Self-abuse</li><li>• Substance abuse</li><li>• Victimization, exploitation in relationships</li><li>• Violence or control exerted toward others</li></ul> |

# Policy Guide for Professionals and Caregivers

One of the biggest fears that adults who work with youth often have is making a mistake by providing too much—or not enough—information about sexuality and sexual health. In some cultures, settings, and communities, talking about sexual health is incredibly taboo, and youth-serving providers may genuinely fear they will lose their jobs or be publicly shamed. To address those fears, this guide provides a list of policies that may be in effect in providers’ states and local communities and may impact what they can and can’t share with youth.

## Sex Education

Sex education requirements will vary based on state law and requirements in different school districts. In a best-case scenario, school districts require comprehensive sex education in schools. However, some school districts may actually be prohibited from providing sex education.

- **State law:** Examine state law to see if there are any prohibitions against what children can be taught in schools. If school districts cannot teach about contraception, assume that youth will need that information.
- **School district policy:** Even with specific state laws, school districts generally get to make the decisions about when and how information is provided to youth. Ensure you know the policies and practices of the school districts in your area. Look for information about what sexual health curricula they teach, if any. Ask about when they provide information in terms of grade levels and semesters. If a youth has missed that content because of school switches, make sure that they get the information in another way and ask the school if there is access to material that the youth missed.

## Access to Healthcare

Both state and federal law dictate when and what kind of healthcare services youth can access without parental consent. If care is provided at a nonprofit, there may also be internal policies that state when youth can receive services by themselves. Providers should know the laws in their state and identify local resources.

- **Regular medical care:** Other than emergency care, most medical care will require consent from a parent or guardian. However, there may be other stipulations related to medical care that you should make sure youth know about.
- **Contraception:** Many states have laws about parental consent for youth access to contraception other than condoms. However, there are some health clinics receiving federal Title X funds that allow youth to receive contraceptive services confidentially.

- **STI testing:** STI testing may require parental consent, but it is less common, at least for HIV, given the potential public health risk.
- **Prenatal care:** In general, a pregnant youth should be able to access prenatal care without parental consent.
- **Adoption:** Youth who become parents have the right to consent to the care of their child, which includes termination of parental rights. Adoption agencies may have more specific requirements for working with youth. Look for local groups that support parents considering placing a child for adoption and connect youth with groups who can share information about their rights in the adoption process.
- **Abortion:** Probably the most complex laws relate to abortion access. The majority of states require some form of parental involvement before an abortion procedure, though there are some states that do not. In some states parental notification and consent are both required, while in other states only parental consent is required. States with notification or consent requirements must provide an option for youth to bypass those requirements via the judicial system.
- **Substance use and mental health services:** Youth may or may not need parental consent for substance use or mental health services. Suicide intervention generally does not require parental consent in emergency situations.

## Child Welfare Policy Requirements/Restrictions

Each state has its own child welfare system. In some cases, systems are administered by the state, while others are run at the county level or by private agencies in collaboration with public agencies. Depending on the specific child welfare system, both state and local laws need to be understood in addition to any administrative rules related to the child welfare system.

- **Rules for foster care providers and child welfare workers:** Some systems have rules about what topics foster parents are allowed or required to address with youth and what topics they cannot address with youth.
- **Independent living preparation:** For youth who are going to turn 18 while in foster care, there may be classes for independent living skills. These may or may not include sexual health topics, and the quality of the classes varies.
- **Expectant and parenting youth:** Foster youth are more likely than their peers to get pregnant and become parents at early ages. In most cases, child welfare systems have piecemeal policies to support youth mothers, but not necessarily youth fathers.
- **Common practice:** Despite what policies are in place, practice may look different on the ground. For example, even if foster parents are required to provide information, they may not actually do so. It is important to get a sense of common practices to understand where there are gaps in information and support provided to youth.

- Confidentiality and mandatory reporting: State laws regarding mandatory reporting may differ with regard to issues like child abuse by a family member and dating or sexual violence by a partner/peer/unrelated adult.

## Local Resources

Adults working with youth in the child welfare system should locate and familiarize themselves with local resources for populations of youth who may need extra support, including LGBTQ+ youth, pregnant youth, young parents, and youth with disabilities. Work with the local sexual assault/domestic violence shelters to access prevention and intervention programs for youth in ongoing unhealthy or abusive relationships. If youth live in an area where there are no services, use national resources. It is critical that youth are able to receive information and support to meet their needs.



## All About Sexuality

The field of sexuality is incredibly broad. It covers everything from biology (like birth control and STIs) to relationships (like communication styles and the elements of a healthy relationship) to media (like texting, social media, and even music lyrics) to identity (like gender and sexual orientation). There are even more topics that could be included, like religion, law, history, clothing, and more. Most people have not received any specific education on any of these topics, and child welfare providers are no different. But you may still be called on to talk with the children and teenagers in your working life about these topics.

This section is designed to support you with knowledge about some of the topics related to sex and sexuality that you are likely to encounter questions about during your work with youth in the foster care system. This information is written with you in mind—it's here in case a young person you are working with comes to you with a question or a topic that you need more information about. If the information you find here isn't enough to answer the question or address the topic, you can refer to the "Additional Resources" section at the back of the book, which has recommendations for you and for child and teen readers.

However, before we get into the content, it is important to know that the information that makes up the field of sexuality changes over time. Some areas—especially the ones that involve music, media, identity, and other cultural ideas—shift more quickly than other areas, like biological information, but all of them change and grow as we learn more about ourselves as human beings.

Four topics that evolve quickly are gender identity, language, sexual orientation, and social media. Each of these topics changes at a rate impossible to keep up with in print publications and are even difficult to keep up with digitally.

On the other side are topics where information and research change more slowly, like contraceptives and sexually transmitted infections (STIs) other than HIV. But even within these topics, there are sometimes changes. For example, gonorrhea is a bacterial infection that has been easily and routinely curable since the introduction of antibiotics in the 1940s, but now there is a strain that is immune to all known antibiotics. Even more recently, there has been work on developing an effective vaccine to prevent it. Because these events have happened in the last three to five years, anything written before then is out of date. Given how the field is advancing, you may find it difficult to keep up to date on the current information, but it is important that we provide youth with the most current and accurate information possible.

These shifts over time are why it is important to keep in mind that, while the information printed here is a good starting point, staying up to date and regularly confirming even the basic knowledge you have is important.

As you read the following information, be aware of your own emotional reactions. If you find the content emotionally difficult, you may find it useful to put the book down and talk with your coworkers

and maybe even a therapist. This will leave you more ready and able to address these topics with the children and teenagers in your care.

A few final notes: The topics below are organized alphabetically. If you want more information after reading through them, head to the “Additional Resources” section at the very end of the handbook.

## **Abortion**

Abortion is one of the most intensely polarizing topics in sex and sexuality. Conversations about the moral and ethical questions surrounding abortion often hold such importance that the medical details are ignored. To address that, here are the medical details of abortions:

### ***An abortion ends a pregnancy***

While many people assume that the notion of when a pregnancy starts is accepted by most people, this is not always the case and is often one of the main disagreements that individuals have when it comes to the topic of abortion.

The stages through which a person becomes pregnant usually begin with sperm being ejaculated into the vagina and then making their way through the uterus and into the fallopian tubes. Next comes ovulation, and then one sperm enters the egg. This process is called fertilization, and the cell structures that are created are called pre-embryos or zygotes. Approximately half of all zygotes pass through the body without moving to the next stage of pregnancy.

Some people believe fertilization is the beginning of pregnancy, while others do not.

After fertilization, the zygote travels down the fallopian tube and into the uterus to implant in the uterine lining (called endometrium) about five days later. Once the zygote implants, it is called an embryo. Approximately one third of all embryos miscarry, and many people miscarry without ever knowing they had been pregnant.

The scientific, medical, and legal communities are in general (although not complete) agreement that implantation is when pregnancy begins.

This conversation is important because it decides whether a medical intervention is considered birth control (which prevents pregnancy) or an abortion (which ends a pregnancy). For the purposes of this book, we are relying on the scientific, medical, and legal understanding of the beginning of pregnancy, which is at the point of implantation.

### ***There are several abortion methods***

An abortion can be medical (with medication) or an in-clinic procedure.

A medical abortion involves taking a pill called Mifepristone, which stops the hormone that supports the pregnancy. Twenty-four to 48 hours later, a second pill called Misoprostol is taken. This breaks

down the lining of the uterus, leading to bleeding like a heavy period. A medical abortion is only done within the first nine weeks of pregnancy. After that, an in-clinic abortion is necessary.

There are two kinds of in-clinic abortions. The first, called a vacuum or suction aspiration abortion, involves inducing a small dilation (or opening) of the cervix followed by inserting a small tube into the uterus through the vagina in order to remove the pregnancy by suction. This process takes five to ten minutes, and the person is usually able to go home after a few hours. This type of abortion can be done until up to 15 weeks of pregnancy.

The second type of in-clinic abortion is called a dilation and evacuation, or D&E. (This used to be called a D&C.) This involves a more substantial dilation of the cervix, after which suction and forceps are inserted into the uterus to remove the pregnancy. This type of abortion involves either sedation or general anesthetic. It takes 10 to 20 minutes, and the person is usually able to go home the same day. This is the type of abortion done after 15 weeks of pregnancy.

After an abortion the person may experience stomach cramps and vaginal bleeding for a week or two. Sometimes people have light bleeding up to a month after an in-clinic abortion.

Both medical and in-clinic abortions cost about \$500, but can range from free of charge to \$1000, depending on the pregnant person's insurance, income, location, type of abortion, and how far along the pregnancy is.

### ***Abortion laws***

Abortion is legal in the United States. However, state laws vary dramatically and continue to change. The Guttmacher Institute maintains current records of abortion laws. These are easy to find with an internet search for Guttmacher and abortion. Some points to research about your state's abortion laws include:

- Whether an abortion must be done by a physician
- Whether an abortion must be done in a hospital
- Restrictions about how far into a pregnancy an abortion may be done
- Whether public funding is available for abortions
- Whether private insurance is able to pay for abortions
- Whether health care providers are able to refuse to do an abortion
- Whether a pregnant person is required to receive counseling on the connections between abortion and a number of negative issues
- Whether a pregnant person is required to wait a specified amount of time between receiving counseling and having an abortion
- Whether a person under the age of 18 is required to have parental involvement, either in the form of parents being informed about the abortion or parents being required to give permission before the person can have an abortion

This last bullet is particularly difficult for young people in foster care or who are wards of the state and who want to access abortion services.

### ***Abortion statistics***

There are many statistics related to abortion that people find surprising because they are different than expected. Here are a few of the statistics that are the most pertinent, as they relate to young people who may be in state care:

- Abortion rates have been falling in the United States since the 1980s and are at their lowest since abortion was legalized. This decline appears to be associated with increased contraception use and, as abortion laws have tightened, increased self-administered abortions.
- Birth control fails sometimes. More than half of women who had an abortion used a birth control method the month they got pregnant.
- More than 65% of abortions happen before 8 weeks.
- More than 50% of women who have abortions are in their twenties. Just over 10% are in their teen years.
- 30% of women having an abortion identify as Protestant, and 24% identify as Catholic.
- In 2013, four women died from complications from abortions in the United States. The year before abortion was legalized in the entire United States, 24 women died from legal abortions, and 39 were known to have died from illegal abortions.

It is important to note that you may or may not find this information useful in your work. It is provided to give you an idea of some of the information currently out in the world regarding abortion. Information cannot make a decision for anyone in a specific situation. Instead, it gives a picture of what some people decide to do. It helps some people to talk about what other people do in certain situations so that they feel less alone in their lives and decisions.

## **Accessing Sexual Health Care**

Sexual health care includes things like birth control, mammograms, pap smears, pelvic exams, pregnancy testing, STI testing, treatment for yeast infections, and more.

Access to sexual health care can range from relatively easy and affordable to all but impossible. There are many things that can contribute to whether a youth is able or not able to access health care related to sexual health: the specific kind of care a person tries to access, where a person lives, their identities, their health insurance, finances, age, and any number of other similar factors. (For more on the ways that these issues interconnect to influence sexuality, see the subsection on intersectionality in this section of the handbook.) When working with a young person who is struggling to access sexual health care, it is important to keep each of these issues in mind.

While Planned Parenthood often offers the most easily accessible sexual health services, there are many cities without a Planned Parenthood clinic, and there may be cheaper or more accessible local sexual health clinics. To find out more about your area, you can do an internet search for your city, county, and state along with “sexual health care clinic” or the specific services that you are looking for. For STI-specific information, you can also visit [www.gettested.cdc.gov](http://www.gettested.cdc.gov) and search by any US zip code.

## Anatomy and Physiology

“Anatomy” refers to body parts; “physiology” refers to the ways that anatomy functions. There are many fields of research and many professions that investigate and treat the sexual anatomy and physiology of the human body. Entire textbooks have been written about specific issues of human sexual anatomy and physiology. Included here is a very broad and general look at sexual anatomy and physiology, followed by a short introduction to the different kinds of genital surgeries.

### *The complexity of gender*

Sexual anatomy and physiology are often talked about in highly gendered ways, with references to men’s and women’s bodies. However, gender is actually a very complex topic with more than just two ways that bodies are made. It is particularly important to acknowledge this when you are talking with a specific individual about their body rather than statistics about everybody’s bodies.

Specifically, understanding what it means to be intersex is an important part of thinking about the physical attributes of sex outside of either male or female. (Look to the “Additional Resources” section for information about people who are intersex.)

### *Normal, average, and actual bodies*

Whether a body part is “normal” or not is often the first question that someone asks a sexuality educator when they meet. It is also one of the most difficult and problematic questions to answer.

It is important to keep in mind the various ways that actual bodies differ from a “normal” or an “average” body. In fact, research has shown that there are very few people who come anywhere close to having an “average” body. In 1945, Dr. Robert L. Dickinson, the president of the American Gynecological Society and chairman of obstetrics at the American Medical Association, took the measurements of 15,000 women ages 18 - 20 and averaged them to create the “ideal” woman. He named her Norma. The Cleveland Health Museum took 9 of her measurements and, together with the Cleveland Plain Dealer, announced a competition with financial prizes for a woman who matched Norma’s averaged body shape. None of the women matched Norma on all nine of the dimensions - and only 40 of the almost 4000 contestants matched on five of them!

So while it would be possible to provide measurements and averages of “normal” bodies, it would not be very useful for people striving to understand themselves and how they fit into the range of human bodies. Instead, it is important to have general information about sexual anatomy and physiology. This allows people to have context about “normality” without specifics that they attempt to compare

themselves to, because so many people are concerned with being “normal” when it comes to sexuality. Indeed, whether a body part is “normal” or not is often the first question that someone asks a sexuality educator when they meet.

### ***A review of body parts***

You may note that this section is not broken up into “male” anatomy and “female” anatomy. There are a few reasons for speaking to this content in a more inclusive way. First, many of these body parts are shared by people of all genders and sexes. Second, assuming what kinds of internal and external anatomy a person has based on their gender expression may be completely inaccurate. (More on this point in the subsection on gender in this section of the handbook.) Third, some people are intersex, which means that they have sex characteristics from more than one common category. Finally, many people will come into sexual contact with sexual anatomy that looks very different from their own. Having a compassionate, deep understanding of the anatomy of their partners increases the quality of their sexual relationships.

This handbook’s handouts on anatomy, however, show “female” and “male” versions. Because of the sheer number of potential differences in intersex bodies, it is impossible to provide a thorough graphic representation in a space like this. Instead, look to the “Additional Resources” for more information and support, particularly if you are working with a youth who is intersex.

Some parts of the human anatomy that are related to sexuality and sexual functioning are:

- **Anus**—While often thought of as part of the digestive system, the anus is in close proximity to the majority of the sexual anatomy. It is also highly sensitive, with its own set of nerve endings. The anus and rectum are part of the anatomy that responds to orgasm through rhythmic contractions that are often considered pleasurable. Some people of all genders find stimulation (including both external and internal) of the anus pleasurable, while others don’t or are turned off by it.
- **Breasts**—Breasts are one of the sexual body parts that are judged, scrutinized, commodified, and sexualized by our culture. Many people have strong feelings about their own breasts and about partners’ breasts relating to size, shape, etc. Most people with breasts have two of slightly different sizes, which can complicate their feelings about their own bodies. As is true of many parts of the sexual anatomy, breasts figure into the reproductive realm (i.e., for breastfeeding) and into the sexual system (i.e., a key component to many people’s feelings of sexual attraction). Individuals can often experience complex feelings due to navigating this sexual dichotomy (e.g., the innocence of babies vs. the naughtiness of sex), which can lead to relational and sexual problems during pregnancy and breastfeeding.
- **Clitoral hood**—This is the tissue that covers and protects the clitoris from overstimulation when it is not aroused.
- **Clitoris**—This is the only body part whose sole purpose is sexual pleasure. Stimulation of the external clitoris (the part of the clitoris that is outside of the body) is relatively well known as an important part of orgasm. However, the clitoris also has an internal part. The internal clitoris

wraps back and around the vaginal canal and is readily stimulated through the vagina. Stimulation of the clitoris is tied very closely to orgasm for many people with a clitoris.

- **Foreskin**—This is the skin that covers the head of the penis when it is flaccid and pulls back over the shaft when it is erect. The foreskin can act as additional lubrication during penetration, giving the penis increased ability to slide in and out. Circumcision removes the foreskin.
- **G-spot**—This is the tissue on the front of the vaginal wall, an inch or so up from the vaginal opening. Some people with vaginas have a substantial G-spot and some people have none at all. It is theorized that stimulation of the G-spot may be related to female ejaculation.
- **Labia**—The folds of skin around the vaginal and urethral openings, extending from the clitoris to the perineum, the labia provide protection for the more sensitive parts of the vulva. There are two sets of labia. These used to be called the labia minora and labia majora, but they are now called the internal and external labia because either might be larger or smaller.
- **Mouth**—The mouth is an integral part of many people's sexuality. Though frequently used for oral stimulation of a partner, from kissing to oral sex, the mouth is rarely acknowledged as part of the sexual anatomy.
- **Nipples**—Part of the breasts for some, but part of nearly all bodies, nipples are highly sexually sensitive for many people. Other people find nipple stimulation to be uncomfortable or even painful. Nipples can add to sexual connection or draw away from it. For people without breasts, the nipples can be a forgotten or ignored piece of the anatomy. For people with breasts who are pregnant or breastfeeding, the nipples may be particularly sore, and stimulation may be more painful than pleasurable.
- **Ovum**—The ovum is the part of the female anatomy that can come together with a sperm to begin a pregnancy. Ova are created in the ovaries and are expelled roughly once a month into the fallopian tubes during ovulation. If an ovum is fertilized, it usually moves down into the uterus and embeds there. If it is not fertilized, it moves down into the uterus, breaks apart, and is reabsorbed into the body. See the handout that diagrams this process in detail.
- **Penis**—The penis is the subject of so much cultural, media, medical, mythological, and personal attention that it could easily be the topic of an entire book. The anatomy of the penis includes the urethra, erectile tissue, arteries, and nerves. The erectile tissue fills with blood, which is what makes the penis become erect. The physiology of the penis is somewhat complex, and there is not sufficient room to discuss it in full here. The “Additional Resources” section at the back of this handbook includes sources with more information on the penis.
- **Prostate**—This is a part of the internal male anatomy that forms the connection between the vas deferens and the urethra. The prostate creates a substantial portion of the ejaculate and it is often highly sexually pleasurable when stimulated through the anus.

- **Scrotum**—The skin that surrounds and holds the testicles, the scrotum is highly sensitive to temperature and ensures that the testicles are kept at the best possible temperature for sperm production.
- **Skin**—While not typically thought of as a part of the sexual anatomy, the skin is actually one of the primary ways through which people engage sexually. The skin is the largest human organ and is intrinsic to every kind of touch, sexual or nonsexual. Skin offers a lot of sexual information about a person, from blushing cheeks to nipples that become hard on arousal. Skin is also an important part of sexual health because it can transmit STIs under certain circumstances. More information about this is included in the subsection on STIs in this section of the handbook.
- **Sperm**—Sperm are the part of the male anatomy that can come together with an ovum to begin a pregnancy. Sperm are created in the testicles, then move into the epididymis to mature. After maturation, sperm either degrade and are reabsorbed into the body or, during arousal, they move up through the vas deferens to the base of the penis. At this point, the sperm mix with fluid from the seminal vesicles and from the prostate before they are ejaculated out of the penis.
- **Testicles**—The testicles hang below the body inside the scrotum and create sperm. Testicles are often in a pair of two different sizes, which makes one hang lower than the other.
- **Urethra**—The urethra connects the bladder to the outside of the body. For people with a vagina, the urethra typically opens in the middle of the vulva between the vagina and the clitoris. For people with a penis, the urethra typically meets with the vas deferens at the base of the penis and then combines to allow both urine and ejaculate to come out of the same opening at the tip of the head of the penis.
- **Vagina**—Like the penis, the vagina would require an entire book to cover the extent of the cultural, media, medical, mythological, and personal attention it receives. The vagina is often penetrated during sexual activities by a penis, fingers, or sex toy. Some people enjoy vaginal penetration, while others don't. The vagina is the path through which a baby is born if the birth is not surgical. The “Additional Resources” section has substantially more information about the vagina.
- **Vulva**—The external female anatomy collectively known as the vulva includes the labia, clitoris, and openings of the vagina and the urethra. Many people grow up incorrectly calling the vulva the vagina. The vulva is typically very sensitive to stimulation. There can be cultural judgment about the appearance of the vulva, and some people even have plastic surgery to achieve a certain aesthetic. However, vulvas vary widely in size, shape, and color. There is not a “right” or a “wrong” way for a vulva to look.

### ***A review of physiology***

Some of the parts of the human physiology that are related to sexuality and sexual functioning are:

- **Female ejaculation**—The details of female ejaculation are still a matter of controversy. Female ejaculation has been attributed to the bladder, the G-spot, and the Skene's gland. Research has

made it clear that female ejaculate is not urine, but has not yet fully answered the question of what it is. What is clear is that some, but not all, females ejaculate. Either way is entirely normal. Certain kinds of vaginal stimulation may make females more likely to ejaculate.

- **Menopause**—This is a shift that people with ovaries in their forties or fifties experience when their ovaries stop producing hormones. Often the most discussed impact is that they stop having a menstrual cycle. The time leading up to menopause, which may last up to a decade or more, is called perimenopause. Physical impacts during perimenopause may include changes in vaginal lubrication cycles, body temperature, sexual arousal patterns, sleep cycles, changes to the hair and skin, cognitive and emotional functioning, and more. There are ways to support and address all these changes.

While hormone replacement therapy has been shown to have substantial risks, some people still prefer it to experiencing the changes that menopause may bring. Others prefer to use herbal and other alternative interventions and managing techniques.

- **Menstrual cycle**—People with ovaries, a uterus, and a vagina typically experience a monthly menstrual cycle between puberty and menopause when they are not pregnant. (Although some people continue to experience vaginal bleeding while pregnant.) The details of menstruation, including the ovulation cycle, are included in the “Handouts” section.
- **Orgasm**—Biologically speaking, an orgasm is the rhythmic contraction of muscles, mostly in the genital area. This includes the anus, pelvic floor, penis, urethra, vagina, and even the nipples for some people.

People experience orgasms due to a wide variety of stimulation, depending on their unique bodies. Many people experience orgasm through genital touch with hands, mouths, another person’s genitals, or a sex toy. Some people experience orgasm because of stimulation to other body parts including nipples, ears, necks, and more. Some people experience orgasms as a result of thoughts alone!

It is best to use the language “experiencing an orgasm” rather than “achieving an orgasm.” For many people and couples, having an orgasm is considered necessary if a sexual experience is to be considered “good.” However, many people do not experience orgasms every time they are sexually intimate. Within this context, sexual activity without an orgasm may be considered “bad” and dismissed as unimportant or “not real.” Because not every person has an orgasm every time they have a sexual experience (in fact, far from it), reducing the language and framework of orgasm from an “achievement” to an “experience” helps to reduce the pressure to have an orgasm every time there is sexual contact.

Multiple orgasms are more common for people with vulvas than people with penises, but they are possible for some people with all different kinds of anatomy.

There is so much information—and misinformation—about orgasms that entire books are written about them. The “Additional Resources” section includes several very good books about orgasms.

- **Puberty**—Puberty marks when the body begins to create and release new hormones: androgens and estrogens. The impact of these new hormones begins with changing a person's secondary sexual characteristics so that they usually begin to look more like an adult. Hormones also begin the reproductive process so that the body ovulates and menstruates or creates and ejaculates sperm.

Puberty also often brings changes to young people's emotional and psychological landscapes, so that they are more complex and more likely to include sexual and romantic attractions.

- **Sexual desire and arousal**—Sexual desire usually refers to the emotional or psychological element of wanting to be sexually intimate with someone. Sexual arousal usually means the physiological changes that often take place when sexual desire is stimulated. Examples of sexual arousal include a sexual flush of the skin; engorged, or erect, genital tissue; and vaginal lubrication.

Desire and arousal are elements of sexuality that, like orgasm, are often stressful when they don't go as hoped, and pleasurable and connecting when they do. Learning more about the physical elements of desire and arousal (anatomy and physiology) is useful when it comes to understanding your own response more deeply, but it is also important to learn about the psychological elements of these parts of sexual activities.

### ***Genital surgery***

One of the biggest controversies around sexual anatomy is related to genital surgery on infants, children, and teenagers. The need for bodily autonomy for all people at all ages is an underlying issue for all elective genital surgery. Here are the three primary focal points of the genital surgery controversy:

- **Circumcision:** This is the removal of the foreskin of the penis.

Circumcision is a culturally divisive issue in the United States, with many people being either strongly in favor or strongly against. In fact, even calling it circumcision is inherently controversial, as many would prefer to include it under the umbrella term "genital cutting."

Arguments about circumcision are often couched in terms of risks and benefits, but what those risks and benefits might be is debatable and remains rooted in culture and preference rather than any agreed-upon scientific metric (Freedman, 2016). However, the Centers for Disease Control and Prevention (CDC) does support the practice. To make matters more complex, in an unpublished document the CDC does seem to acknowledge that delaying circumcision until puberty or later allows the individual to have full bodily autonomy while still having the opportunity to reap any and all potential benefits. Delaying genital surgery of infants until puberty, when the individual is able to make the decision for themselves, is sufficient for many, but not all, people who are pro-circumcision.

For couples who are having a child with a penis and who each feel differently about circumcision, the issue can be fraught with anger, resentment, and an inability to accept their partner's point of view as legitimate. This issue is not only about communication skills, but also about deep belief structures about sexuality.

- **Genital cutting:** This is most often defined as cutting of the labia, clitoris, and/or clitoral hood. It is sometimes called female genital mutilation. While it is less common than in other countries, genital cutting does occur in the United States.

There is often an assumption that people who have experienced genital cutting will invariably perceive the experience to be abhorrent. However, the reality is far more complex. When genital surgery is a cultural rite of passage, it can often be felt as a communal experience that has ties to positive and in-group feelings. (The same can also be true of male circumcision.) The wide range of possible surgeries associated with genital cutting make it difficult, without much more information, to accurately predict what sort of psychological or physical impact genital cutting may have on an individual.

- **Genital surgery on intersex infants:** There is a wide range of physical attributes that result in a person being classified as intersex. Because sexual characteristics include primary and secondary sexual characteristics, hormone balance, and chromosomal makeup, classifying a person's sex can be very complex. However, when an infant is known immediately to be intersex, it is because their genitalia are not readily identifiable as "male" (with a penis and testicles) or "female" (with labia and a vagina).

Historically, doctors have often done unnecessary and harmful surgeries to align intersex infants' genitals with the way genitalia stereotypically looks. Doctors have sometimes done this with parents' consent and sometimes without. The surgery requires the doctor to "pick" a set of genitals, often without considering the other elements of sex assignment and always without considering the individual's gender identity. Long considered by the medical profession to be "helpful," the physical and psychological harms of this kind of surgery have been thoroughly proven. While many doctors are now advising against these surgeries, there are some who continue to do them (Human Rights Watch/interACT, 2017). A person who is intersex may or may not choose to have genital surgery when they are fully through puberty and have a clearer understanding of all the ins and outs of their bodies and their gender identity. This later option allows the individual to have full choice and autonomy around their body rather than having elements of it chosen without their consent.

## BDSM

The first part of this section describes BDSM. The second part addresses teenagers and how to talk with them about BDSM interests.

The term "BDSM" describes certain kinds of consensual sexual contact that involves power differentials and sensation play. The letters can stand for bondage, discipline, dominance, submission, sadism, and masochism. Within this kind of relationship, the people involved typically agree on a "safe word" that stands in for someone saying "no" or "stop." In order to engage in BDSM safely, all the people involved need to be fully educated about what they are doing and what the safety risks are. They also need to be very self-aware, have a high level of self-control, and be able to communicate and plan with their partners.

There is a growing understanding of BDSM sexual interactions in the public eye. The books (and movies) in the Fifty Shades of Grey series introduced many people to the topic, including many youths as young as middle school age. The Anastasia and Christian storyline, however, is not a good blueprint for how to have a healthy BDSM sexual relationship. If adults are interested in reading BDSM erotica, they can do an internet search for “BDSM erotica better than Fifty Shades of Grey.” The internet is also rife with the specifics of the many and stark problems with the story, such as the way the characters overtly ignore basic BDSM safety standards.

Neuroscience shows us that teenagers rarely have the level of self-awareness, self-control, and communication skills that are necessary for safe BDSM sexual experiences. Most people need more years of having sex than teenagers are able to have, combined with support, information, and mentorship from adults who are very experienced on how to have BDSM sex safely. Given that it is morally and legally inappropriate for knowledgeable and skilled adults to offer this kind of BDSM mentorship to teens, teenagers are not able to receive training or education about BDSM sex. However, this does not mean that some teenagers are not attracted to or aroused by BDSM sex.

If you become aware of a teenager who is interested in BDSM, it is critical to be understanding and nonjudgmental. Many adults with BDSM interests say that the interest goes back to when they were teenagers, or even children. Indeed, it is clear that BDSM can be a lifelong interest, and shaming someone for it is only harmful in the long run. Instead, listen, accept, and be clear that it is difficult for minors to engage in BDSM activities in ways that are physically, emotionally, and sexually healthy given the need for intense self-awareness and the need to learn from others (who, as mentioned, are themselves adults, thus posing a legal and moral barrier).

## **Body Image**

The psychology and sociology of the body are deep and complex topics. Many cultures provide a specific understanding of what a body “should” look like, and nobody actually has that body. Just like there are no “average” bodies and people are given contradictory advice about how much and what kind of sexual activities are acceptable, there is no one who actually has an “ideal” body. The issue is that the standards by which bodies are judged contradict themselves—they impose absolute goals that can’t all be true at the same time. Some examples are that breasts are supposed to be large (but not too large!) and perky throughout life, while penises are supposed to be large (but not too large!) and either definitely intact or definitely circumcised (depending on whom you ask). While there are deep judgments, it is rarely clear exactly what one should, in fact, look like and how anyone might be able to choose these elements of their physical appearance anyway. The consequences for having a body that is not a cultural ideal (which no one can actually have, so everyone faces these consequences) can include self-doubt, eating disorders, and sexual problems.

There are many ways that body image and sexuality interact with each other. Poor body image can make every part of sexuality harder, from attraction and arousal to communication and orgasm. Therefore, it is very important to consider the ways in which cultural assumptions about bodies and their relative

attractiveness have a trickle-down impact on the quality of not only a person's general mental health, but also their sexual and romantic well-being.

For example, if a teenager has a poor body image, they may feel like they "deserve" to be treated poorly in a relationship because they're not beautiful enough to "get" anything better. They may end up feeling grateful that someone wants to date them or have sex with them because they assume that nothing better will come along because they are not attractive enough. Indeed, sometimes people will manipulate others into having sex with them by telling the other person that they are ugly, but they're still willing to have sex with them. A strong body image is critical to young people being able to walk away from this kind of emotional abuse.

## Communication Styles

Passive, aggressive, passive-aggressive, and assertive are four common communication styles that one may experience when working with youth in the foster system. It is important to note that all individuals may engage in aspects of these communication styles. However, it is also worth noting that many young people have a particularly difficult time using, and requiring that the people they are dating use, an assertive communication style. (Definitions for and explanations of assertive communication can be found in the Communication Styles Guide and Handout.) This difficulty in figuring out what type of communication someone is using is why comprehensive sexuality education includes information about communication styles.

Asking someone out (or inviting someone to be sexual for the first time) and ending a relationship (or a specific aspect of a relationship, like no longer having sex but still wanting to be friends or needing to be co-parents) are times when the quality of communication style often gets worse, trending either toward passivity or aggression. At the times when people feel the most vulnerable, they are most likely to fall back on unhelpful communication habits in an attempt to soften their own or the other person's potential pain.

However, the benefits of healthy communication are substantial. Not only do they lay the groundwork for a healthy relationship, and all of the benefits that come with it, but healthy communication styles also allow for consensual, pleasurable sexual experiences.

Within a child welfare setting, it is vital to dedicate time to specifically address communication within sexual and romantic relationships because youth can be so harmed by the poor communication style examples in their personal lives combined with poor cultural assumptions, poor media messaging, and ingrained habits. For example, it is often difficult for youth in foster care to distinguish between assertive and aggressive communication, and they may have been previously punished for asserting their own needs.

We address communication and relationship quality extensively in the "Handouts" section, with one handout focusing specifically on communication styles.

## Gender Identity

As this language may be new to you, we recommend you begin by reviewing these definitions to provide a framework for understanding the rest of the section. (If these definitions are confusing, head to the handout on identity for a deeper introduction to the topic.)

- **Biological sex**—A complex group of physical factors that are variously assigned to male, female, and intersex categories.
- **Gender expression**—The way(s) in which a person shares information about their gender through their hair, makeup, clothes, etc.
- **Gender identity**—A person’s internal sense of how they relate or do not relate to the social constructs that their culture aligns with the sex they were assigned at birth.
- **Sex assigned at birth**—The sex (girl/boy) that is assigned to a baby when they are born and that is assumed to relate to their gender identity.
- **Sexual orientation**—The combination of identity, attraction, and behavior that collectively informs our understanding of the type of person someone may want to be sexual with or be in a relationship with.

Gender identity is a construct that has been largely misunderstood, assumed to be the same as a person’s sex assigned at birth, instead of being considered something special and different. Another common, inaccurate assumption is that people who identify as gay or lesbian are a different gender than their sex assigned at birth. This assumption is based on gender expression rather than gender identity. This inaccurate conflation of gender identity, gender expression, and sexual orientation also has a long and problematic history. In actuality, gender identity exists across several continua and for many people is entirely separate from their sex assigned at birth.

Our cultural understanding of the ways that gender identity (which is an internal feeling) differs from gender expression (an external display that may or may not be connected to the internal feeling) and sex assigned at birth (a short description of the external genitalia) has expanded. Through that expansion, we have come to learn that gender identity and the way that it connects or doesn’t connect with gender expression and sex assigned at birth is a critical component of feeling happy and accepted. Not feeling accepted or understood because of one’s gender identity can have a drastically negative impact on a person’s mental health. Creating a place for children and teenagers to feel safe and comfortable to develop and express their gender can have lasting positive impacts.

We have included a handout called “What’s Your Identity?” in the “Handouts” section to allow you to talk about these issues with children, teenagers, and adults as needed. There is also a “Gender Dictionary” so that everyone can have the same definitions.

## Healthy and Unhealthy Relationships

There are so many ways in which a sexual or romantic relationship can be healthy and unhealthy, and there are many educational programs that detail those ways. Substantially more time is spent in many educational programs discussing unhealthy relationships than discovering what healthy relationships look like.

But children and teenagers need models and conversations about what healthy relationships look like too. Without a model for healthy relationships, many people assume that unhealthy patterns are the norm, to be expected, and part of all relationships. This is particularly true for children in the child welfare system, who have likely experienced many examples of unhealthy relationships. Happily, youth are often more excited to discuss the details of healthy relationships than unhealthy relationships.

Help youth create their own definitions of a healthy relationship as compared to an unhealthy one. For example, what a supportive partner might do when a person is busy at work or school is very open to interpretation. Some people might consider it supportive if their partner with a higher sex drive agrees to having only quick sex every other day during a busy time. Others would consider it supportive if their partner makes and brings them dinner and doesn't expect to be in touch as much during a busy time. Going beyond general language like "supportive" to discuss specific sets of actions and deeds one's partner could do helps children and teenagers understand whether a relationship is truly healthy or unhealthy.

The "Handouts" section includes "Columns and Shadows," which provides insight into teasing apart these sometimes-complex issues while providing a blueprint for relationship health.

## Intersectionality

Intersectionality is often raised as a framework for understanding the institutionalized structures that have the potential to negatively impact minority groups. It is important to consider this lens when looking at minority identities like race/ethnicity, gender identity, sexual orientation, health status, disability status, economic status, and educational background. Intersectionality describes the ways in which minority identities collectively make a bigger impact on physical and psychological well being than might be thought when considered individually. This means that not only is it unwise to consider each minority identity individually, but that doing so actively discounts their overall impact on wellbeing.

The majority of the structures in the United States are designed to support people who are White, cisgender, male, heterosexual, healthy, not living with a disability, affluent, and well educated. The more of these categories a person does not fit into , the more cultural and economic structures they are excluded from.

To highlight the importance of taking an intersectional lens regarding sexuality, consider the life experiences of a White, straight, cisgender man compared with the life experiences of an Egyptian, lesbian, transwoman. While it is, of course, possible that the first person faces life challenges, the

second has substantially more institutional hurdles to overcome in her pursuit of life, liberty, and happiness. People from privileged backgrounds may have trauma in their histories, but people of minority statuses must contend with more societal barriers that can cause mental health issues and traumatic experiences.

Many elements of identity are highly visible, like gender expression and race. However, there are also identities that are less visible, like sexual orientation, educational access, and some disabilities, and these all impact the ways in which people are related to when they are out in public and the ways in which child welfare providers will come to understand and talk with them in session. Remembering the possibility of invisible identities and the ways they may intersectionally impact children and teenagers is critical to supporting them.

## Intimate Partner Violence

**Note:** Abusive relationships are now typically referred to as a person experiencing intimate partner violence (IPV). However, many teenagers connect with language around teen dating violence rather than IPV.

The issues around IPV are such that many people of all ages, but particularly younger people, are unaware of what a relationship on its way toward violence may look like and what forms violence may take. Forms of violence other than physical violence often go unrecognized. This may in part be due to the romanticization of violence in movies, television shows, and music. This includes controlling behaviors, and emotional, financial, psychological, sexual, and social violence. While these forms of IPV are often seen as precursors to physical violence, they should, in fact, be considered unique forms of IPV in and of themselves. The following is a short list of examples of partner behaviors that may be an indication that a relationship is unhealthy and has the potential to lead to IPV:

- Has bursts of anger, even if they are followed by deep regret
- Checks your cell phone and social media accounts without your permission
- Makes you doubt your friendships
- Isolates you from friends and family
- Tells you what you can and can't wear
- Constantly needs to be in contact with you and know who you are with
- Makes the relationship too serious too quickly
- Insults you or people you care about
- Blames you when they overreact
- Causes you to worry frequently about how they will react

It is important to know that an abusive partner may exhibit one or two of these signs, all of them, or even none of them.

The ways a person controls their partner are often very subtle initially, using their partner's feelings of empathy and love to erode their connection to their community and consideration of their own needs. Over time these controlling and manipulative behaviors can escalate. These are the primary points of concern to take into account when initiating a discussion around intimate partner violence. When you are talking with a teenager, using words like manipulation, empathy, and love, rather than violence, often allows for an easier entry into the dialogue. This dialogue may require explaining certain terms and allowing youth to put definitions into their own language.

More about intimate partner violence can be found in the “Handouts” section.

## Kink

The first part of this section describes kink. The second part addresses teenagers and how to talk with them about kinky sexual interests.

While there is no official definition of kink, it broadly refers to interest in or arousal due to unconventional sexual activities. Kink can include BDSM, for example, but there are other kinds of sexual interest that also fall under the umbrella of kink, like a sexual interest in feet, leather, role-play, spanking, etc. People are not able to change what or who they are sexually attracted to, including their kinks. However, many people feel judged for their kinks rather than accepted because of them.

Most people with kinks need them to be a part of their adult sex lives, at least to a small degree. Disclosing a kink to a new partner can be difficult because the discloser risks rejection. It is even common for people to realize that they need to disclose a kink to a partner they have been with for years because not including their kink in their sex life is becoming too difficult.

When a child welfare worker or foster parent is kink-aware and kink-friendly, they are able to listen and understand when a child or teenager comes to them with questions, feelings, or concerns. The adult in this situation is able to let the young person know that their feelings are a typical and natural part of their sexuality and, as a sexually active adult, can be a regular part of their sex life if they and their partner both want it to be.

## Language

Language describing sexuality is ever-evolving. Because conversations about sexuality are often hidden rather than openly discussed, there is a revolving door of slang terms to refer to sexual body parts and sexual acts that goes back centuries. See the timeline handout about historical slang in the “Handouts” section.

Staying current with slang terms can be difficult, particularly because each peer group will have in-group slang that you can only come to know through asking. To achieve a common language, ask the young people you work with which sexual words they prefer and to define any words they use that you are not familiar with.

In addition to sexual slang, there has recently been an explosion of language creation and reclamation to describe sexual orientations and gender identities. Attention to detail around this language is critical in order for children and teens who identify using these terms to feel accepted and seen as who they are. For the purpose of creating a space that is affirming and accepting of every identity, we recommend asking every youth for their pronouns. Making this an integrated habit rather than something to be done when a clearly gender-diverse youth presents themself has the capacity to shift your organizational culture toward inclusivity. Many times, we recommend referring to young people using the singular they/them. Using these terms when you first meet a young person until you are made aware of their preference can create a welcoming and affirming environment. If you use an incorrect word, apologize. Many people feel more hurt when someone does not acknowledge their misstep than by the misstep itself.

## Masturbation

Masturbation is when a person sexually stimulates themselves, which is why it is also called solo sex. It often, but not always, includes touching and stroking the clitoris or penis. Other body parts that are often included in masturbation are the anus, testicles, and nipples.

Many people masturbate. There are jokes that suggest anyone who says they don't masturbate is lying, but that's not true. Many people go through phases where they masturbate rarely or not at all, and some people never masturbate. Honoring the choice not to masturbate is just as important as honoring the choice to masturbate.

Historically there have been myths about masturbation that were harmful. Examples include masturbation resulting in pubic hair growing on the palms and going blind. Most people are not concerned about these things nowadays. Instead, some people have physical and emotional concerns about masturbation, like worrying that it ruins sex with a partner or means that they are cheating on their partner.

It is important to reassure young people that masturbation is usually safe, and that with proper communication it is unlikely to negatively impact a sexual relationship with a current or future partner. This is difficult for many couples to fully agree with, because they may see masturbation as a form of cheating. Solo sex, however, meets different kinds of sexual needs than partnered sex. Some people are able to get all of their needs met through partnered sex, while others are not. Masturbation may also be used by the person in a sexual partnership who has a higher sex drive, to accommodate for fewer sexual interactions with their partner. In this way, masturbation may actually be beneficial to relationships.

In child welfare settings, particularly group homes or residential treatment centers, youth tend to lack privacy. They may share a room with other youth or be assigned a higher level of adult supervision for safety reasons. This lack of privacy often leads to punishment when youth are found masturbating. Professionals and caregivers should allow youth privacy as much as possible and redirect behaviors to private spaces where other youth are not present.

## Pregnancy and Birth

Pregnancy and birth are important for all people to know about. Even for people who cannot or do not want to experience pregnancy and birth, the topic looms large as a part of sexual decision making, as part of our cultural dialogue, and as something that friends and family experience.

This is, obviously, an extremely condensed description of what happens during pregnancy and birth. Given that there are many entire books that cover only this topic, this section gives only a summary overview to help get you, and a young person, started thinking about it. There are more resources in the “Additional Resources” section of this handbook.

### ***Sex awareness and pregnancy***

While it may be surprising to learn that many people are unaware of exactly what sexual acts can result in a pregnancy and which cannot, that is the reality. This is especially true of teenagers who have not had access to formal comprehensive sexuality education or to informal education through caring, educated adults who are close to them. The majority of children and youth in the child welfare system fall into these categories. Not understanding the process by which pregnancy begins is particularly problematic when someone does not want to be pregnant (or does not want their partner to be pregnant) but does not know how to prevent pregnancy from happening. Comprehensive sexuality education is immensely helpful in addressing that problem.

### ***Stages of pregnancy***

The stages through which a person becomes pregnant usually begin with sperm ejaculated into the vagina and then making their way through the uterus and into the fallopian tubes. Next comes ovulation, when the egg leaves the ovary and moves into the fallopian tube, and then one sperm enters the egg. This process is called fertilization, and the cell structures that are created are called pre-embryos. After fertilization, the pre-embryo travels down the fallopian tube and into the uterus to implant in the uterine lining (called endometrium) about five days later.

The scientific, medical, and legal communities are in general (although not complete) agreement that implantation in the uterus is when pregnancy begins. This conversation is important when considering whether a medical intervention is considered to prevent pregnancy or to end pregnancy. To add to the confusion, pregnancy is considered to be between 37 and 42 weeks long, with the weekly count beginning on the first day of the last menstrual period because this is the date that most people are able to remember precisely.

The approximately 40 weeks of pregnancy are broken up into three trimesters:

**First trimester:** This is when the basic building blocks of a human system develop. This includes everything from the nervous and arterial systems to the gastrointestinal tract and the genitals. Because of this explosion of system development, the embryo is very sensitive to chemicals, medications, and elevated stress hormones that may be in the pregnant person's system. Between 10% and 25% of all known pregnancies end in natural miscarriage due to chromosomal abnormalities or other issues at the very basic level, with 80% of miscarriages happening in the first trimester, usually before 12 weeks. Even more probably end before the person knows that they are pregnant. The first trimester ends around week 14. People in their first trimester of pregnancy often feel physically out of balance because of the dramatic increase in hormones in their bodies. They may vomit, experience exhaustion, urinate frequently, and experience emotional ups and downs. Other people feel fine!

**Second trimester:** This is from week 14 to week 26. The second trimester builds on the first, with bone, sensory, skin, and lung development. This trimester is often the physically easiest for the pregnant person. There are fewer changes in their body compared to the first trimester, and they usually are not uncomfortably large yet.

**Third trimester:** This begins at week 26 and ends at birth. The third trimester includes less new development than the first two, but includes a lot of fetal weight gain. The fetus grows larger and stronger in order to sustain themselves outside of the uterus. Lung development continues into the earlier weeks of this final trimester. People in their third trimester of pregnancy often feel physically overwhelmed from carrying around the extra weight of the fetus, placenta, and amniotic fluid.

### ***Stages of vaginal birth***

Labor and delivery are the final stages of pregnancy. A birth is considered "term" between 37 and 42 weeks, with weeks 39 and 40 being the ideal, and most common, time to give birth. (Twins are often considered full term at 37 weeks.)

Vaginal birth includes three stages:

**Stage 1:** This begins with early labor, which lasts from the onset of regular, rhythmic contractions until the cervix dilates to 3 cm. Active labor occurs at 3–7 cm of cervical dilation, and transition occurs at 7–10 cm of cervical dilation. The first stage of labor is typically the longest, sometimes lasting up to 24 hours or longer. While staying calm and relaxed is ideal for the baby and the person giving birth, it can be incredibly difficult during this stage due to the length of time it can take. Transition, which is the last part of stage 1, can be the most physically and emotionally difficult.

**Stage 2:** This begins when the cervix is fully dilated and continues until after the baby is born. Stage 2 is also sometimes called the pushing stage. Many people prefer this stage to stage 1 because it is more active. Stage 2 can last from a few minutes to a few hours. The final part of this stage, when the baby is born, is usually the most exciting for everyone involved.

**Stage 3:** This is when the placenta, which has been carrying nutrients to the fetus and waste products away from it, disconnects from the uterus and is expelled from the body through the vagina. Stage 3 is rarely discussed or shown; some people are surprised to learn that birth actually continues after the baby is born.

The process of giving birth vaginally is important to some people's identity, while others dismiss it as a small piece of parenting. It is important not to assume the feelings, values, and assumptions a person may have about past or future birth experiences.

### ***Choices surrounding birthing***

The decision of how and where to give birth is a very personal one, and one that young people in the child welfare system may not be able to freely make. While there are many arguments about the costs and benefits of various birthing methods, the most important thing is that the pregnant person feels safe in their environment and that they have access to increased levels of medical care should they need it.

For some people, this means birthing at home with a midwife, while for others it means birthing in a birth center or a hospital. Some people prefer to labor and deliver drug-free, while others schedule a C-section. It is critical to support young people with as much accurate information as possible in order to allow them to make as many decisions about their labor and delivery process as is possible within the welfare system, although their autonomy in this process varies from state to state.

### ***Relationships and pregnancy***

It may not be surprising, but is nevertheless worth stating, that during and after pregnancy, a couple's romantic and sexual relationships can change. While sexual activity during pregnancy is overwhelmingly safe and encouraged in a committed relationship, the issues that arise can be both physical and emotional. This is even more complicated for teenagers who are pregnant and then give birth, and who may feel that the only reason their partner is with them is to have sex. In this case, teenagers may decide to have sex in ways and at times that are uncomfortable, painful, or exhausting to them in order to keep their partner's attention.

The pregnant person's overall changing body impacts which sexual positions are accessible and comfortable. Additionally, there may be changes in the vagina and cervix that affect the degree to which penetration is pleasurable. Because of the changes in hormones, pregnant people also often have shifts in their sex drives that are different from their pre-pregnancy norms and even different between trimesters. After birth, many people find themselves both exhausted with 24-hour parenting and emotional about their bodies, which are usually different from their pre-pregnancy bodies.

Some people experience postpartum issues like the "baby blues," postpartum depression, and postpartum psychosis. This can make connecting and bonding with others, including children, family, and friends, more difficult. While these feelings can be a natural response to changing hormone levels in the body, the lack of open dialogue surrounding these issues can be damaging to those experiencing it. This is especially true for teenagers, who are likely to have fewer resources than adults. For these reasons, it is important to pay close attention to young people's emotional landscape after birth.

Some of the warning signs to look for include mild to severe depression, mood swings, unexplainable crying, irritability, and emotional disconnection. It is critical that people who are experiencing these, or even more dramatic mental health issues like psychosis, after a birth are in contact with an expert in the field. They need to be formally evaluated and provided with opportunities for appropriate medical interventions as needed.

A pregnant person's partner may also experience shifts in their feelings about sexual activity during and after pregnancy. Some people are particularly aroused by their partner's pregnancy, seeing it as evidence of their ability to create life and attributing it to an attractive femininity. Other people see a shift in their partner away from a sexual being to an archetype of motherhood, which may decrease their sexual attraction to their partner. Some people find their attraction to their pregnant partner waning because the partner is gaining weight. This is very common among younger people who may still be holding on tightly to a cultural norm of beauty that is thin and without blemish.

Ultimately, however, the potential impact on sexual arousal to a pregnant partner may be surprising even for the individual. It is critical that a pregnant person's partner not blame the pregnant person for their shifts in arousal. Rather, it may be more useful for them to come to understand their shifts through dialogue with a caring adult whose insight they value, and then return to dialogue with their partner about their evolving sexual relationship.

In addition to the relationship changes described above, there is also an increased risk for abuse in a relationship to occur during and after a pregnancy. This can be due to ambivalence about the pregnancy and increased levels of stress. It is important to acknowledge and discuss this potential change in open, nonjudgmental ways.

## Racial Stereotypes

Children of color are often sexualized at early ages and seen in less positive lights than their white peers. This reality exists in the broader context of racism in our society and may be experienced acutely by the youth you are working with. Black children, particularly, bear the brunt of this cultural and social set of beliefs about children of color. Black girls are seen as less innocent and less in need of protection than White girls of the same age, while Black boys are seen as more suspicious, judged to be older than they look, and more often presumed guilty of crimes than White boys of the same age. However, none of these assumptions about Black children are true.

These perceptions actively harm children because of the ways in which adults engage with them as a result of those perceptions. When an adult believes a child to be a certain way, whether that is more (or less) suspicious, in need of protection, or likely to commit a crime, they will shift how they approach and interact with that child. Therefore, it is adults' responsibility to ensure that they do not allow these common, harmful cultural perceptions of children of color to actively harm the children they are working with. However, these presumptions about Black children and children of color are often implicit, which means that people are unaware that they hold them. In order to support children and youth of color, professionals and caregivers must become aware of their implicit biases and actively work to be anti-racist.

Harvard's Project Implicit ([www.implicit.harvard.edu/](http://www.implicit.harvard.edu/)) allows individuals to test their own implicit biases around a range of issues, including race. This is a great first step for adults in the child welfare world to get a sense of where their implicit biases may be the strongest so that they can work hard to break down and move past those biases. Even people who believe that they do not have racial biases may still have elements of bias deep in their subconscious. The children and youth in the child welfare system will always benefit from adults working on eradicating their implicit biases.

## Religion

Religious traditions say so many different things about sexuality that there is no way to cover them within this resource. But one critical aspect about the intersection of sexuality and religion to consider in the child welfare setting are any discrepancies between a youth's sexuality, including their gender identity, sexual identity, sexual behavior, or patterns of sexual attraction, and what the religion of the adults in their life prescribes.

It is important to support youth's understanding of the differences among a religious, moral, or ethical description of what is sexually "right" or "wrong," a psychological or biological description of what is sexually "right" or "wrong," and what the individual person feels is "right" or "wrong" for them. This can be very reassuring for young people. For example, the way that a person thinks about their own masturbation habits may be very different when viewed through different lenses. Masturbation is regarded as unacceptable by several common religious traditions but is deemed common and healthy by the fields of psychology and medicine.

In some cases, youth may enter the foster care system due to lack of acceptance or abuse because of their gender and sexuality. Religion is sometimes used as a tool to reinforce discrimination and suppress the exploration of gender and sexuality. Providers should ensure that youth are not required to attend any religious service if they do not want to. Providers should also try to connect youth to religious and spiritual leaders who can provide acceptance and support when desired by the youth.

## Safer Sex

There are two primary things that people try to prevent during sexual contact: STIs and pregnancy. While many people would love to prevent heartbreak or a bad sexual connection, there is not yet a way to make those negative outcomes any less likely.

When deciding which safer sex method(s) to use, it is critical to provide youth with accurate information regarding what the method prevents, how the method works, and the method's effectiveness.

### *STI prevention*

Methods of STI prevention vary by type of infection transmission. They include:

- **Preventing fluid transmission or skin-to-skin contact that can transmit an infection.** This is done through external condoms (which are put on the penis), internal condoms (which can be put into

the vagina or anus), and dental dams (used during oral sex) to provide a barrier of latex or other material between the fluids of the two people involved. Condoms also provide a small amount of coverage so that there is reduced skin-to-skin contact. Dental dams provide greater coverage between skin-to-skin contact, but are only intended to be used during oral sex on a vulva. All three of these methods are around 80% effective at preventing infection.

- **Taking a vaccine.** There are vaccines that inoculate the body against HPV and hepatitis infections. These vaccines are 90% or more effective. Additional vaccines, including against HIV, are currently in production.
- **Taking preventative medication.** HIV medication is complex and constantly improving. As of 2017, the CDC has determined that when a person who is HIV positive has an undetectable viral load due to taking antiretroviral medications, that person is not infectious. This means that these medications are 100% effective. An HIV-negative person can take a daily dose of PrEP (pre-exposure prophylaxis), a medication that inhibits contracting HIV. For people exposed to HIV, a third type of medication, PEP (post-exposure prophylaxis), can be taken within 72 hours of exposure to dramatically reduce the likelihood that they will contract the virus.

Using two methods of prevention (called dual protection) at once is always more effective.

### **Pregnancy prevention**

Often called contraception or birth control, pregnancy prevention is a matter of stopping sperm from joining an egg and/or keeping cells that would have resulted from fertilization from implanting in the uterus. This can happen by preventing a sperm from entering the reproductive system where an egg might be present; preventing an egg from being released from the ovary into the reproductive system where a sperm might be present; preventing the movement of the fallopian tubal cilia so that the pre-embryo does not reach the uterus; or reducing the endometrium in the uterus so that it cannot support implantation. Pregnancy prevention falls into five categories that work in different ways:

- **Barrier:** These methods of contraception stop the sperm before it enters the fallopian tubes, sometimes before it even enters the vagina. The most common form of barrier contraception is the external condom. Other barrier methods include the internal condom, diaphragm or cervical cap (which are inserted into the vagina to cover the cervix), and the IUD (which can be made from copper rather than plastic and hormones). The copper IUD can be implanted as a form of emergency contraception within 5 days after unprotected penile–vaginal intercourse.

With the exception of the copper IUD, this kind of contraception provides the benefit of being used only at the time of sexual activity, and so does not affect the body over a longer period of time.

External condoms are available over the counter to any person of any age in the United States. They are available for free at some health clinics (and websites such as [teen source](#)). Internal condoms can be purchased online and in some select pharmacies and adult toy stores. All other barrier contraception require a prescription.

Barrier methods range in effectiveness from 80–99%.

- **Behavioral:** This type of contraception involves a person making choices about their sexual activities based on the desire to prevent pregnancy. Two of the most common examples are abstinence (where the person does not engage in unprotected penile–vaginal intercourse when pregnancy is most likely to occur) and withdrawal (where the penis is taken out of the vagina prior to ejaculation).

The effectiveness of behavioral methods depends substantially on how exactly the method is used, but with strictly accurate use, it ranges from 73–100%.

- **Chemical:** The only prevention method in this category is spermicide, which is a gel or cream that is usually used along with barrier methods such as condoms and diaphragms to increase their effectiveness. While possible to use alone, spermicide has a lower reliability than most other birth control methods.
- **Hormonal:** One of the most common forms of contraception, hormonal birth control works by decreasing the likelihood of either fertilization or implantation. The hormones can enter the body in a number of ways, including a daily pill (the most common method), a quarterly shot, a ring inside the vagina, a patch stuck on the skin, a small plastic implant in the upper arm, or a plastic IUD, which is a T-shaped item placed in the uterus.

Two of the available forms of emergency contraceptives are also hormonal. These pills, often referred to collectively as “morning after” pills, can be taken after otherwise unprotected penile–vaginal intercourse to reduce the chance of pregnancy. They vary in their effectiveness and should be taken within the first 24 hours of unprotected sex (both drop in effectiveness after that point but can still be taken within the first five days after intercourse).

People have different reactions to contraceptive hormones. In addition to the expected (and intended) impact, some people find that these hormones reduce their sexual arousal, increase their anxiety or depression, or change their reproductive cycle in problematic ways. Negative reactions may be reduced by changing to a contraceptive with a different balance of hormones. Some people experience serious side effects of hormonal contraception and find that they are happier and feel better when they use non-hormonal methods of contraception.

In the United States, hormonal contraception is available only through a healthcare practitioner’s prescription. Laws about the age a person can be prescribed hormonal contraception without parental consent vary from state to state.

Hormonal contraception is 90–99% effective when taken correctly. In order to have such a high degree of effectiveness, the hormones need to be constantly introduced into the body.

- **Surgical:** These are permanent methods that sever or block the fallopian tubes or the vas deferens so that the eggs or the sperm are not able to move through them. (While removing the uterus and/or ovaries has the impact of a permanent surgical contraceptive, those procedures should only be done when there is a clear medical need rather than as a method of pregnancy prevention.)

Surgical methods are typically offered only to adults after they have had biological children, even when younger people ask for them and are clear that they do not want to biologically reproduce.

Surgical methods are 99% effective.

Talking with young people about the many safer sex options is not necessarily easy when it is outside your realm of expertise. However, medical doctors are often overbooked and spend little time per patient, and young people may find that they are left with questions and are confused about the biological details even after an appointment. Sexual health educators may or may not be available in your community to have more specific conversations with youth. The “Additional Resources” section has websites and other sources that may be useful to you and youth as you learn about the various potential options. There is also a resource in the “Handouts” section of this handbook that will allow you to discuss options with youth.

## Sexual Consent

Consent is often reduced to simplistic sound bites rather than discussed in all its complexities. Two of the most common examples of simplified cultural dialogue about consent are “no means no” and “yes means yes.” Both these phrases were useful in their historical moment, both add to the conversation, but both are insufficient for a real conversation about consent in daily life.

However, for people who have not even been exposed to the sound-bite level of dialogue about sexual consent, these are critical starting places for dialogue and learning. A slightly more in-depth example of consent is the viral “[Tea and Consent](#)” blog post, which was turned into a video that discussed why it is not okay to have sex with people who are asleep or unconscious (“Unconscious people don’t want tea”). This is the next step in discussing and teaching about consent after the first two sound bites.

After a general introduction to the topic of consent, there are many ways to dive deeper into conversations about consent. Here are some questions you can start with: How do people make decisions about what kinds of sexual activities they want or do not want to do? What makes it hard for a person to communicate those decisions to a partner? What makes it hard for someone to hear their partner’s decisions about sexual activities? What are some ways in which people communicate about consent without using words? Are these effective or ineffective ways to communicate about consent?

When you are talking with young people you will likely find a wide range of knowledge and understanding of consent. Some may not even understand that no means no. Others may have a sophisticated level of information based on personal research. Providing them with new kinds of ideas and perspectives on consent over time, rather than all at once, may be a useful approach. Another approach is to look at questionable examples of consent from movies, television shows, song lyrics, and other forms of media, and discuss a variety of ways of assessing consent. There is an example of this kind of activity in the “Handouts” section.

## Sexual Orientation

Sexual orientation, more or less, describes the gender of person someone wants to be in a relationship or have sex with. A person's sexual orientation is a combination of three aspects:

- **Identity**—A combination of the way a person understands themselves internally and the way they describe themselves externally.
- **Attraction**—The type of people to whom a person feels drawn romantically or sexually. Romantic and sexual attraction may be in alignment or may be different from each other.
- **Behavior**—A description of the kinds of sexual or romantic connections that a person has over time.

All three of these elements may be relatively stable across a person's lifespan, or they may be fluid. The constancy or fluidity of identity and attraction is not something that a person chooses.

For many people all three of these pieces are in alignment, or are basically the same. For example, if someone identifies as a lesbian, is primarily attracted to other women, and flirts with or is in a relationship with another woman, all three elements of her sexual orientation are in alignment. But this is not the case for everyone. For example, consider a person who identifies himself as heterosexual, who is attracted to people across the gender spectrum, is in a relationship with a woman, but has sex with men in secret. This person's sexual orientation is not fully in alignment, possibly for a range of reasons. Perhaps he fears coming out as bisexual or queer, or he hasn't thought much about his identity, or he isn't aware that a person could identify as anything other than straight or gay. For people whose three aspects of orientation are not in full alignment, thinking through each of the aspects individually can provide useful insight and support their self-knowledge and decision making.

In addition to these three aspects, sexual orientation has come to be understood as referring to both sexual and romantic attraction. Romance and sexuality can be very connected, or they can be entirely separate. The "What's Your Identity?" handout includes a visual demonstration of one way that sexual and romantic orientation can be understood as connected or different. The "Gender Dictionary," also in the "Handouts" section, gives an in-depth description of current language around sexual orientation.

One of the pivotal aspects of sexual orientation for many people who identify as LGBTQ+ is "coming out," or telling people about their sexual orientation. While many people think of coming out as a one-time event, sharing sexual orientation with new people is actually a continuous, lifelong process. Some examples include making new friends, beginning school in a new place, having a new foster family or case worker, and having a new mental health practitioner. Particularly when you meet a new child or teenager who identifies as LGBTQ+, or when someone you know comes out to you, it is very important to be supportive with your words, body language, facial expressions—everything. It can make the difference for whether that young person will come to you for help in the future or not.

## Sexual Rights

In the United States, we understand many parts of the human experience to be our basic rights that cannot be removed by our government or by other individuals. While the implementation of this understanding is not perfect, it is a goal we strive for.

None of the rights that are outlined in our government documents are directly related to sex or sexuality. Indeed, their absence is at times notable and problematic. For example, women are not mentioned at all in the Declaration of Independence or in the Bill of Rights. Therefore, the rights that women come by in the United States are extrapolated rather than inherent. This is true of all things related to sexuality, like access to sexual health care, same-sex marriage rights, sexuality education, and more.

The potential role that sexual rights can play in a person's individual understanding of themselves and their sexuality is immense. It is not, however, an idea that many people talk about or that is often shown in the media. Nevertheless, discussing sexuality within a rights-based model may be very useful for people who are trying to understand why they should or should not be able to do something or why what someone else did to them was not okay. The "Handouts" section includes the World Association for Sexual Health's Declaration of Sexual Rights along with a discussion of how it might be incorporated into sessions.

## Sexually Explicit Media

Sexually explicit media (SEM) is a broad term that includes both pornography and erotica. The difference between the two may or may not be important, with erotica being sexually explicit with artistic intent and pornography being sexually explicit without artistic intent. The two can look extremely similar given that the difference lies exclusively with the creator's intentions rather than the final product.

To say that SEM is a politically charged topic would be an understatement. There is not currently an agreement on whether pornography is ultimately helpful and supportive of a healthy sexuality or actively harmful to a healthy sexuality. While many people believe strongly that the research indicates one definitive answer or the other, the fact is that even seasoned professionals disagree on which direction the research definitively points. The arguments go something like this:

- “SEM is great! When people are able to release some of their sexual urges through SEM use, those urges are more controllable. SEM functions as a release valve. Furthermore, it’s a great boost to the economy, lots of people think it’s a fun way to relax and be sexual when they’re alone or with their partner, and it can provide useful information for people seeking to learn about sexuality.”
- “SEM is horrible! When people use SEM, it affects the ways in which they are sexual outside of that experience and makes them more likely to degrade their partner (especially if they are partnered with a woman). Furthermore, SEM draws viewers into deeper and deeper levels of hardcore sex and leaves them always wanting to push the boundaries as far as they can.”

The reality of the situation, like most of the unanswerable arguments about humanity (e.g., “nature vs. nurture”), is that the final answer will probably be somewhere in between. For example, the impact of SEM might have more to do with the nature of the specific images rather than the idea of sexual explicitness itself.

However, for some people SEM clearly becomes problematic for themselves or in their romantic/sexual relationships. Being fully aware of your personal feelings about SEM and its potential impact on a person’s sexuality is important to any conversations about SEM. While people under the age of 18 are not legally supposed to have access to SEM, we know that they do have access, either through SEM that they and their friends or partners create themselves or through the internet.

Talking openly with youth about the SEM that they have seen, their feelings about it, and their understanding of it is important. They need to hear that SEM does not usually show sex the way it really happens. Instead, it often shows amped up, narrow examples of how some people have sex.

## Sexually Transmitted Infections

The language around the bacterial, viral, and parasitic infections that are most commonly transmitted via sexual contact has evolved over the years. In the past, the majority of the public perceived these infections, long known as “venereal diseases” (or VD), as gross, dirty, and something to be hidden. In an attempt to shift the dialogue so that people would be willing to disclose having one of these infections to a partner, the medical community shifted the language to sexually transmitted disease (STD).

Over time, however, STD also took on a negative connotation. The word disease itself is problematic, as it suggests that there are symptoms, while these infections often have no symptoms. For these reasons, the medical community made a second shift in the early 21st century to sexually transmitted infection (STI). This guide uses STI as the primary term, although if a person is more comfortable using STD, there is nothing inherently wrong with using that language when you are talking with them.

### ***Categories of STIs***

There are three categories of STIs, each with unique aspects that are important to know about.

- **Bacterial STIs:** Usually curable with antibiotics, bacterial STIs do not usually have a negative impact if they are treated soon after they are contracted. Symptoms may include genital discharge and pain when peeing, but many bacterial STIs do not have any symptoms. This is why testing is such an important issue. If bacterial STIs are left untreated, they may cause scar tissue in the reproductive organs (primarily the fallopian tubes, although also possibly the vas deferens) that inhibits reproductive functioning. This is the way by which STIs may make a person infertile, or unable to have a baby.

The most common bacterial STIs are chlamydia and gonorrhea, with syphilis coming in a distant third. A strain of gonorrhea not curable by currently known antibiotics has recently emerged, and there is a team working toward a vaccine for gonorrhea.

Bacterial STIs are transmitted through sexual fluids including vaginal lubrication, ejaculate, and anal fluids. They may also be transmitted through blood and breast milk, although this is not as common. When there is an infection on the skin (as is the case with some stages of syphilis), it is possible to contract a bacterial STI through contact with that area of the skin.

- **Viral STIs:** Considered medically incurable, viruses are not alive and so cannot be “killed” in the same way that bacteria and parasites can be. Therefore, while there are treatments to reduce the impact of viral STIs on the body, there are no known cures other than the body naturally expelling the virus on its own. This does happen sometimes, particularly with human papillomavirus (HPV). There are immunizations for hepatitis and some strains of HPV.

While bacterial STIs are relatively similar, viral STIs are all very different. Getting tested is critical.

- **Hepatitis** causes liver problems usually characterized by yellowing of the skin and flu-like symptoms, and can also be transmitted through sexual activity.
- **Herpes** (caused by herpes simplex virus, also called HSV) is among the most common viral STIs. It creates small sores either around the mouth (where they are often called cold sores) or around the genitals.
- **HIV** (human immunodeficiency virus) causes the viral STI that gets the majority of attention. HIV infection generally has no symptoms after a short feeling of general illness, but it slowly degrades the immune system.
- **HPV** infection, another common STI, causes unregulated cell growth, which can either manifest as warts or as cancer (although it can also have no symptoms at all).

Viral STIs are transmitted through bodily fluids and skin-to-skin contact when there is an infection on the skin (as is the case with HPV and herpes). No STIs are transmitted through bodily fluids like saliva or sweat.

- **Parasites:** STI parasites are tiny creatures that live and thrive in the human genital system. The most common is trichomoniasis (also called trich), which is a parasitic bacteria. Others include scabies and pubic lice (also known by the slang term “crabs”). Symptoms include genital itchiness; with trich there may also be a strong odor.

STI parasites are readily cured with a cream or by shaving the genital area (in the case of pubic lice). They are transmitted through close contact with an infected person.

### ***Communicating about STIs***

Having a general understanding of sexually transmitted infections will allow you to support young people who may find themselves infected or potentially infected and need to work through the biological and psychological issues that come with those experiences. Having information about what exactly STIs are, how to prevent contracting them, and how to treat them is a crucial part of maintaining a sense of control over one’s own sexuality. (See the subsection on safer sex in this section of the handbook.)

Sexually transmitted infections impact relationships far beyond physical issues. For example, some STIs can lay dormant for years or even decades before they express themselves through symptoms. This means that if someone has not been regularly tested, their current partner may assume that they have recently cheated because they suddenly have STI symptoms. This is why understanding the biological implications of STIs can be critical to effective dialogue and connection within the relationship.

For someone who has an incurable STI (like herpes or HIV), communicating about that with a new partner, or even sometimes a long-standing partner, can be difficult. Open communication regarding incurable STIs can lead to an improved level of communication overall in a relationship. It is important for professionals working with youth to ensure that they have access to accurate information and support in discussing STIs with partners, including how and why to disclose current or past infections.

## Social Media

The ways people engage with each other digitally and process larger cultural trends are constantly changing.

Take dating, for example. Ads related to seeking romantic engagement first appeared in the late 1600s. This was the first precursor to what would become online dating. Computers figured into the dating world early, in the 1960s, when Harvard students could answer questions and get a list of potential dating matches.

A lot has happened in the last 50 years, though. By May 2017, almost 50 million of the 325 million people in the United States had tried online dating—meaning about 15% of the entire population had tried to connect romantically through digital means. From JDate.com (for Jewish singles) to PositiveSingles.com (for HIV-positive singles) to FarmersOnly.com (for single farmers), to the ubiquitous Match.com or OkCupid.com, which offer a more general approach to finding romance, there is a dating site to match virtually anyone’s needs. More recently, dating apps like Tinder and Grindr have overtaken dating sites as places to make friends, find relationships, and hook up.

In any online space there is the potential that someone might be lying about who they are, including their age, sex, gender, and interest in the other person’s well-being. Ensuring emotional safety in online relationships, and both physical and emotional safety when moving a relationship from an online platform to a real-life setting, is critical. Many young people have had conversations about these important factors of meeting and building relationships online, but making sure that they are thinking through them in the midst of what might be an exciting new relationship remains crucial.

The same general appeal and expansiveness of online dating applies to all social media sites—they make more people accessible as potential dates. There are specific sites and communities that you may be completely unaware of that teenagers you know are deeply engaged with. Even if a comprehensive list of all social media sites were included in this handbook, it would be out of date within a few months. So rather than attempting to educate yourself on the potential social media that teenagers take part in, invite them to educate you on the parts that they find most fulfilling.

One thing to be aware of is that social media can be a way to support mental health as well as a way to tear down mental health.

For teenagers, particularly, social media can provide a much-needed connection to people who understand and appreciate their identities in ways that their families, social workers, foster families, and immediate peer groups may not. For young people who identify in ways that are counter to the community around them, including their sexual orientation, gender identity, artistic impulses, personal expression, religious beliefs, race, or more, digital communities can be lifesaving.

There are, however, social media sites and specific communities that can be devastating to people's identities. Much of the dialogue about the harms of social media talk about the ways people bully others, about distributing pictures without consent, and other related issues, but there are also social media networks created with the express intent of supporting unhealthy behaviors such as eating disorders. Pro-anorexia sites are one example, with the goal of supporting anorexia. Two examples are [anorexicdiettips.com](http://anorexicdiettips.com) and [myproana.com](http://myproana.com).

Supporting teenagers (and sometimes children) around sexuality and social media will require you to have an understanding of their specific patterns and interests. So ask them to share with you in ways that show you are honestly interested rather than trying to restrict or monitor their behavior. Ask what they're doing online, why they like it or don't like it, and how it supports them to be happier, healthier people.

There are four aspects of all digital media, including social media, that are important to share with youth to support their online decision making. These four ideas come from danah boyd (who prefers her name in all lowercase letters). Her book *It's Complicated: The Social Lives of Networked Teens* offers a comprehensive understanding of the specific issues surrounding digital media. These are the four most important aspects of digital media to remember, according to boyd:

- Persistence (the durability of online expressions and content)
- Visibility (the potential audience who can bear witness)
- Spreadability (the ease with which content can be shared)
- Searchability (the ability to find content)

Talking about these four components during any interaction with digital media, including social media, allows users to make better judgments about their social media choices. This kind of information is useful regardless of the kind of social media that a teenager (or child, or even adult) participates in.

## **Trauma**

All children and teenagers who are in the child welfare system have experienced trauma. The degree to which that trauma impacts their understanding of sexual dynamics, their trust in others, etc., may vary, but trauma remains an elemental piece of the puzzle of who they are and how they will relate, sexually and romantically, to others.

One of the things that we know about trauma is that it can affect how people feel inside their own bodies long after the trauma has stopped. These experiences are often triggered by something they are currently feeling, seeing, or thinking about, but it's not always clear why someone is triggered. Triggers may make people feel the things that they felt at the time the trauma was happening and or it may make their bodies shut down and feel nothing at all. Both of these kinds of reactions have the potential to impact a person's sexual development and their sexual activities.

It is important that your work with youth seeks to actively avoid causing further trauma. When we recognize that trauma has the potential to affect the way in which a youth processes information, we have the opportunity to help them mitigate the impact of trauma on their current and future relationships. Look back to the Trauma-Informed Sexual Health Framework toward the beginning of this handbook for more information on trauma and to the "Handouts" section for more support. The Trauma and the Body Handout is the best place to start.

## Unintended Pregnancy

About 45% of all pregnancies in the United States are unintended. When a person learns that they are pregnant without plans to be so, they have three potential ways to move forward:

- Maintain the pregnancy and parent the baby
- Maintain the pregnancy and find adoptive parents
- Terminate the pregnancy

For some people it is immediately clear which of these three paths to take. For others, the choice can be incredibly difficult due to lack of access to health care, their own physical health, the level of support they get from partners, family, or friends, and other issues. Youth who are unclear about which path is right for them may find the following information helpful.

- **Maintain the pregnancy and parent the child:** About 60% of unplanned pregnancies are carried to term, and the vast majority of babies are parented by the pregnant person and their partner. The complexities of this path are generally well known but are rarely discussed in explicit detail. Considering everything from financial to social and emotional issues is useful to a fully informed decision-making process.
- **Maintain the pregnancy and find adoptive parents:** A small percentage of pregnancies are carried to term and then voluntarily relinquished to adoptive parents. The exact number is unclear, however, because the adoption industry is not well reported.

The modern adoption process is very different from how it was in the past. The pregnant person usually looks through lists of prospective adoptive parents, which can include pictures, biographies, and statements about parenting. Based on this information, the pregnant person chooses the family they want to parent the baby after it is born. While agreements and paperwork can be signed at this point, many states require the pregnant person to wait

until after the birth to give complete parenting rights to the adoptive parents. Most modern adoptions are at least partly open. This means that the birth parent is permitted to have some contact with the adopted child. The contact can range from once-a-year pictures and letters to frequent visits, depending on what the birth parent and the adoptive parents agree on.

One of the infrequently discussed parts of this choice is that when a person is pregnant, other people often want to talk about the pregnancy. Strangers, acquaintances, and others unaware of the pregnant person's intention to find adoptive parents ask questions about things like name choices, timeline for returning to work or school, etc. When a person has decided to carry a pregnancy to term and find adoptive parents, they will need to decide how to respond to these kinds of well-meaning, but potentially difficult, inquiries.

- **Terminate the pregnancy:** Extensive information about abortion can be found at the beginning of this section of the handbook.

It's possible to be content with or to regret each of these three choices in the days, months, and years following. Because of this, the decision should be made thoughtfully. For some people, even a thoughtful decision will be made quickly, while for others it will take time, deliberation, and conversation.

Unfortunately, the decision to terminate a pregnancy must be made relatively quickly. It is possible to take much more time to decide whether to parent a baby or to find adoptive parents. It's critical to have access to all available information in order to make an informed decision.

There are two kinds of clinics that provide information about termination and other pregnancy options:

1. Reproductive health clinics that offer abortions (often, but not always, Planned Parenthood clinics)
2. Crisis pregnancy clinics (CPCs), also called pregnancy resource centers (PRCs).

It is important to understand the differences between these two kinds of clinics.

Reproductive health clinics present medically accurate information about termination with the goal of supporting individuals in making their own decisions about whether to terminate or carry the pregnancy to term.

CPCs, however, are created to convince people not to have an abortion, and are known to widely disseminate incorrect or exaggerated "facts" in order to further that goal. It is critical for teenagers to know which kind of clinic they're going to so that they are fully prepared for and invested in the kind of support they will receive.

## Handouts

In this section you will find 24 of our favorite handouts to use with young people (you can download digital versions here: [unhush.us/HCWP](http://unhush.us/HCWP)). These handouts were developed by UN|HUSHED and other professional organizations and can be tailored to work with young people who are asking questions or demonstrating needs for information on various topics related to sexuality.

Each handout is accompanied by a guide with our suggestions for use. We encourage you to adapt these resources to best fit your and the youth's needs, and to familiarize yourself with each handout while referring to the "All About Sexuality" section. Each youth is different, so the handouts and their associated uses are designed to be flexible. Make sure you take time to familiarize yourself with the guide and the handout before trying to use them with youth.

Most of the guides include ways to use the handouts with youth individually and in groups. Deciding which approach to use will depend on the specific youth in question. For example, youth who are identified as experiencing sexual or physical trauma may need to have certain topics introduced to them individually rather than in group settings. Some topics may raise additional issues if they are addressed in groups where two or more of the participants have apparent sexual or romantic tension. And other topics work really well when used as icebreakers, to create and build community connection and norms, or to address community-level concerns. When you plan to discuss a topic related to sexuality in a group setting that is not typically devoted to sensitive topics like this, it is important to let all participants know about the topic beforehand.

Depending on the setting in which you work you may have different amounts of time with each youth. We encourage you to think about how to best use these materials given the amount of time you may have with a youth and their ability to process the information in a meaningful manner.



## Anatomy

These handouts are diagrams of the typical internal female and male anatomy. Dr. Karen Rayne and Jessica Smarr, MPH, developed both the handouts and the following instructions for the UN|HUSHED: Middle School Curriculum.

Before you begin, be sure to familiarize yourself with the information about anatomy and physiology in the “All About Sexuality” section of this manual, particularly the part about what it means to be intersex. This is a common area where people lack information and understanding.

The handouts can be used in different ways depending on your role, the age of the young person, and the capacity in which you are working with the young person. These can be used with someone who is in puberty, having questions about their body, or who has incorrect information about their body or a partner’s body. For young people who have experienced sexual abuse, labeling body parts can be particularly important.

### Objectives

- Expand youth’s knowledge about female and male anatomy
- Clear up misinformation youth might have about female and male anatomy
- Promote thought and dialogue about how physical anatomy relates to sexuality

### Individual Conversations

#### *Caregivers*

You can tell the youth that you are going to discuss sexual and reproductive anatomy. It is ideal to provide the youth with both the female and male handouts so they can learn more about a range of anatomy. However, sometimes youth may need to focus on their own or another’s anatomy in specific ways. After looking at the handouts generally, go through the applicable information that is included in the two sections below. Allow time for any questions or processing that needs to be done.

This topic has the potential to be sensitive for some youths due to vulnerable and uncertain feelings concerning their body. Allow time for the youth to adjust and process the topic. Validate your youth’s insecurities, or possibly their confidence, on the topic.

Throughout the discussion, evaluate and validate how your youth is feeling and process any thoughts or questions that they may be having. Learning about anatomy and physiology can be rich in growth and conversation.

#### *Case Managers / Direct Care Staff*

Familiarize yourself with the handout on your own. This will help you become a more knowledgeable resources for youth when questions related to anatomy come up, as well as help you shed light on misinformation being shared amongst youth and professionals.

### ***Counselors***

While using a trauma-informed lens encourage youth to become more aware of their own anatomy by examining their female or male anatomy in private. Everyone's anatomy has unique characteristics specific to them. So, it is important to know what our own anatomy looks like. For instance, if you have never looked at your own anatomy, then you won't be able to clearly describe a genital bump to a doctor or respond to a question about how long it has been there. Encourage youth to privately use a mirror to look at their anatomy and learn what it looks like. Depending on the youth's placement, you might have to discuss agency policy that is applicable to this exercise. Alternatively, you and the youth can brainstorm appropriate places to do this such as the bathroom or in the shower.

Normalize the need for someone to be aware of one's own body. Youth might feel curious, embarrassed, or even repulsed by this idea. It is important to validate these emotions and other reactions youth might have. Explore with youth what it is like to feel that way toward that part of their body. Ask youth how their feelings about their body function in their life, especially in regard to their sexual health, their sexuality, and accepting themselves (their self-compassion). Have youth imagine what it would be like to have more positive feelings toward their anatomy. Spend time thinking of steps youth can take to promote a more positive view of their sexual and reproductive anatomy.

## **Group Conversations**

### ***Part 1***

Anatomy can be an embarrassing topic for youth to talk about, especially when surrounded by their peers. Give group members a few moments to react to the content of the handouts and any embarrassment they might feel. Consider going over the handout in smaller groups with members who identify as the same gender. If needed, redirect group members by asking the group to brainstorm reasons why it is important to be knowledgeable about anatomy. Give permission for youth to step out of the room if any of the information becomes uncomfortable. Make sure to follow up with youth who do decide to step out, and if needed, encourage them to speak with their counselor or another trusted adult.

As you go over the handouts, allow time for group members to ask questions and to gain clarification. Acquiring physical models of the sexual and reproductive systems of men and women can enrich the learning process for group members and help make the information seem less arbitrary or conceptual.

### ***Part 2***

Provide youth with magazines and other art supplies after going over the handouts. Ask group members to recreate the sexual and reproductive systems discussed using different images and art supplies. Group members can work independently or in pairs. Encourage group members to be creative and put their own unique perspective on the information. Have willing group members share their creations and explore their reasoning behind the design. Group leaders can also ask youth how they integrated the information they learned into their creation. Lastly, if the space is available, offer group members the opportunity to hang their creations around the room to promote group cohesion.

## Additional Information

### ***Female anatomy***

- Tell the youth that this is a side view of the abdomen of someone with the most common female anatomy. Point out the anus and explain that it is attached to intestines, which are not pictured.
- Point out the ovaries. Most people born with ovaries are born with two of them. Ovaries release hormones and contain eggs, which are called ova. When someone with ovaries is born, they already have all the ova that they will ever have stored in their ovaries. See the handout “The Egg in the Reproduction Process” for more details about how the ova are released from the ovaries.
- Point out the fallopian tube. Explain that fallopian tubes connect the ovaries to the uterus. There are usually two fallopian tubes—one for each ovary. When a sperm and an egg meet for fertilization and potential pregnancy, it occurs in a fallopian tube.
- Point out the uterus. The uterus is about the size of a fist. This is where a fetus will develop if someone becomes pregnant.
- Point out the cervix. The cervix is the very bottom part of the uterus and is where the uterus and the vagina meet.
- Point out the vagina. The vagina is a multi-talented muscular canal. Explain the following points:
  - The vagina goes from the uterus to the vulva.
  - When the vagina is stimulated, it can result in sexual pleasure.
  - If sperm are ejaculated into the vagina, they can travel up through the uterus into a fallopian tube and fertilize an egg.
  - When menstruation occurs, tissue and blood are shed from the uterus and exit the body through the vagina.
  - The vagina is self-cleaning. It does not need to be cleaned.
- Point out the clitoris. Most of the clitoris, which contains a great number of nerve endings, is found inside the body. Only a small part of the clitoris, called the head or glans, can be found outside of the body. Stimulation of the clitoris often results in sexual pleasure.

### ***Male anatomy***

- Tell the youth that this is a side view of the abdomen of someone with the most common male anatomy. Point out the anus and explain that it is attached to intestines, which are not pictured.
- Point out the scrotum. The scrotum is skin that contains the testicles. The scrotum and the testicles are often known as the “balls.”
- Point out the testicles. Most people born with testicles are born with two of them, though only one can be seen on the handout. During puberty, the testicles begin to produce sperm. The testicles usually continue to produce sperm throughout life.
- Point out the epididymis. The epididymis is a tightly coiled tube found on the back of the testicles.

After sperm are formed in the testicles, they travel to the epididymis and continue to develop.

- Point out the vas deferens. With arousal and stimulation, sperm move out of the epididymis and travel up into the vas deferens. Before ejaculation, the sperm is mixed with seminal fluid produced by the seminal vesicles and prostate gland. Ejaculation describes the release of semen, also known as ejaculatory fluid (or the slang term “cum”).
- Point out the prostate and seminal vesicle. Most people born with a penis and testicles are born with two seminal vesicles, though only one can be seen on the handout. Each ejaculation can contain hundreds of millions of sperm, but most of the ejaculation is fluid produced by the prostate and seminal vesicles. The prostate gland secretes liquid that can help the sperm survive a trip through the vagina, uterus, and fallopian tube. When the prostate is stimulated, usually by inserting something into the anus, it can result in sexual pleasure.
- Point out the bulbourethral gland, also known as the Cowper’s gland. Most people born with a penis and testicles are born with two bulbourethral glands, though only one can be seen on the handout. These glands secrete a fluid that travels through the urethra prior to ejaculation. This fluid helps neutralize the urethra to create a friendlier environment for the sperm. When it exits the urethral opening, this fluid is known as pre-ejaculatory fluid or by its slang term, “pre-cum.” Pre-ejaculatory fluid may contain sperm that were still in the urethra from recent ejaculations.
- Point out the urethra. Ejaculatory fluid and urine exit the body through the urethra in the body of someone with a penis. For almost all these people, the pathway from the bladder “closes up shop” when the body becomes aroused so that urine is not mixed with ejaculatory fluid.
- Point out the penis. The penis is filled with spongy tissue. When someone with a penis is aroused, their penis often fills with blood and becomes erect. However, erections can occur for no apparent reason, especially when people are first going through puberty. When the penis is touched, it often results in sexual pleasure.

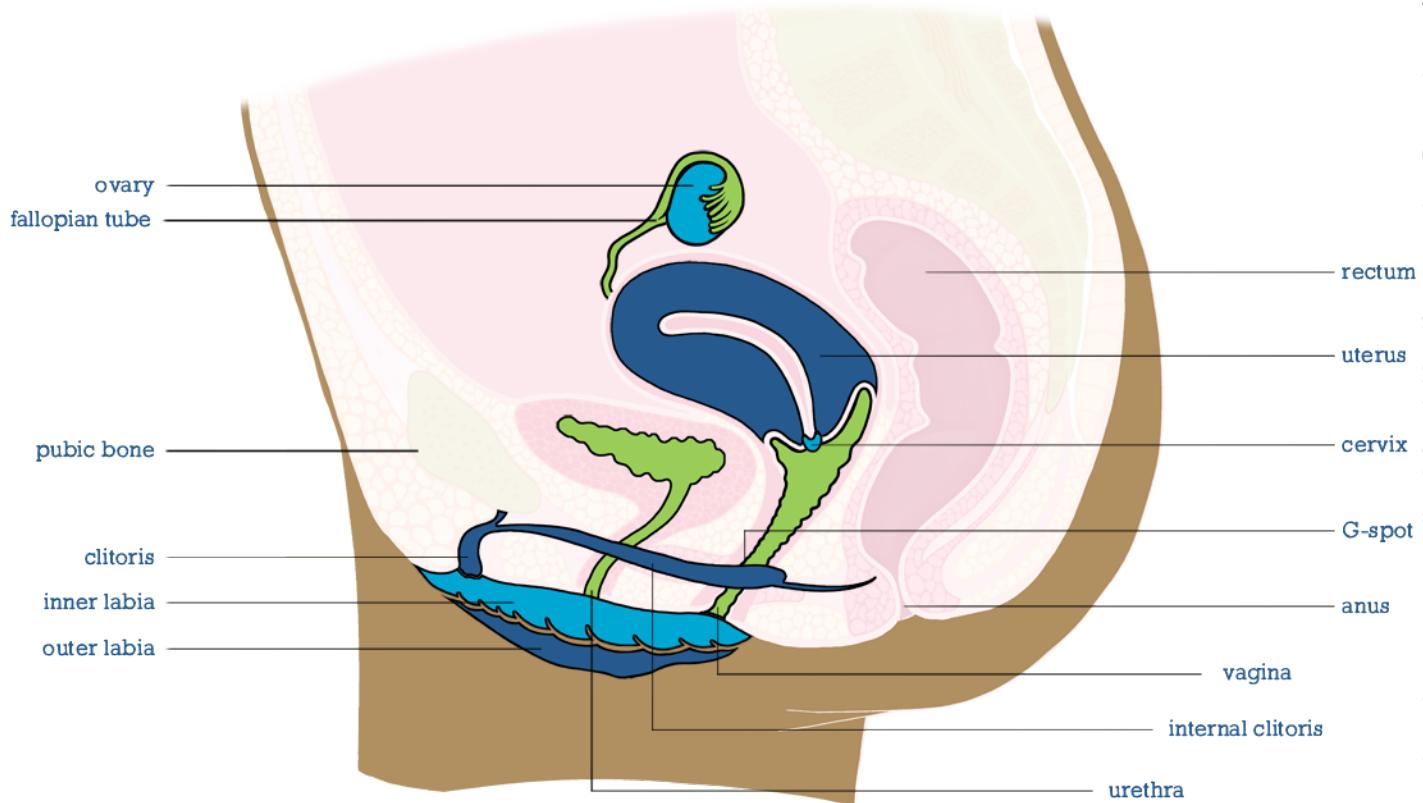
## A Suggested Wrap-Up

Ask the youth if they have any questions about the handouts or the information. Allow them time to process any thoughts, feelings, and questions they may have. You may want to let them take the handouts, think about them, and return to discuss in the next session.

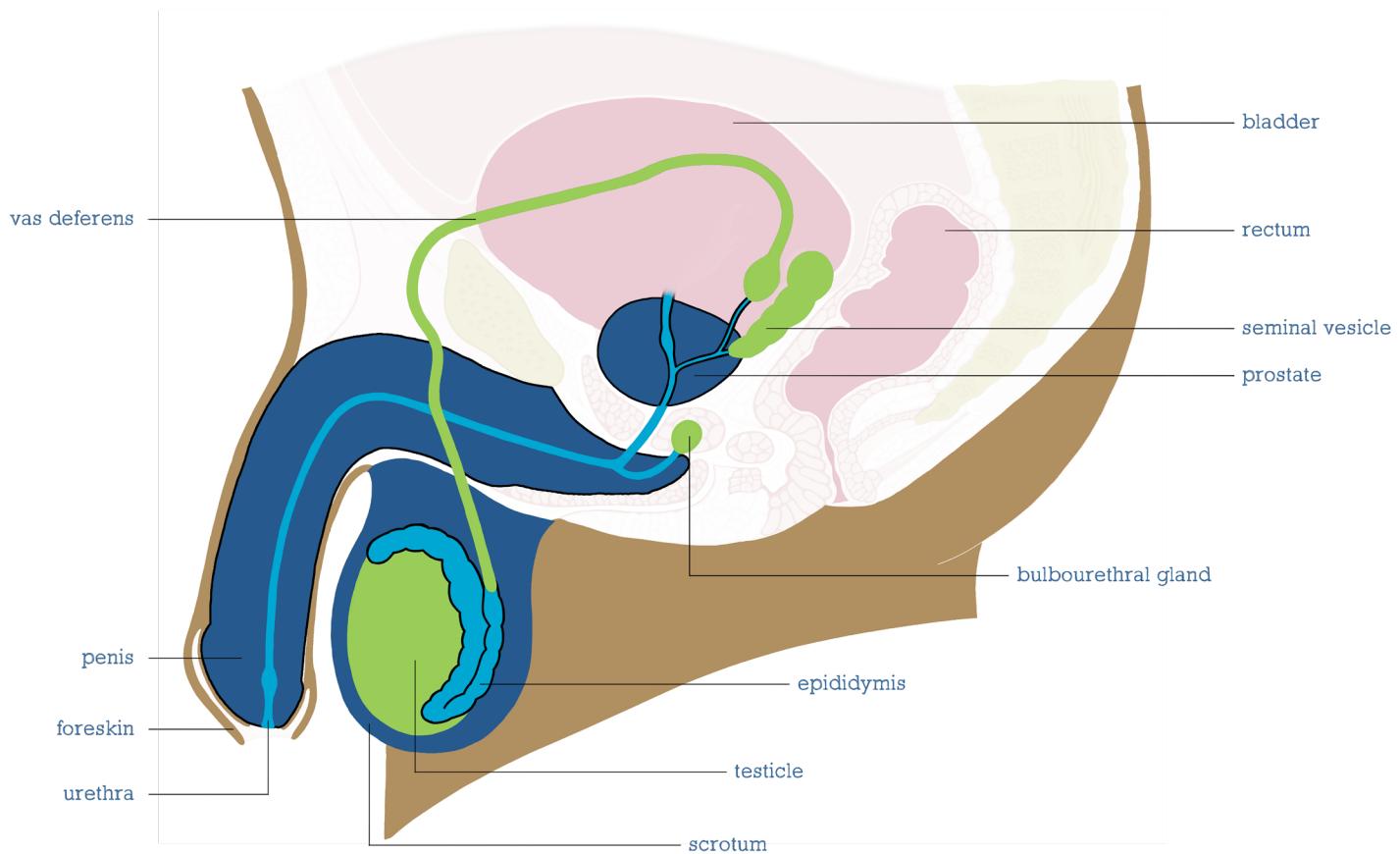
Some possible questions you could ask the youth include:

- How were you feeling as we discussed this topic?
- Did you learn anything new?
- Did you learn anything that you thought you already knew, but you were wrong about?
- Why do you think it is important to learn about anatomy?
- How do you think this knowledge could impact a person’s sexuality?
- How do you think this knowledge might impact your sexuality?

## Anatomy: Typical Female



## Anatomy: Typical Male



## Columns and Shadows

“Columns and Shadows” was developed by Sam Killermann and Dr. Karen Rayne. The handout is a great way to (re)introduce the concepts of healthy and unhealthy relationships to youth. This handout can also be useful for youth who are just starting to date, currently in an unhealthy relationship, or who have a loved one currently in an unhealthy relationship. It is useful to provide additional resources for youth who are interested in seeking help addressing or learning more about unhealthy relationships.

### Objectives

- Recognize the signs of respect, equality, safety, and trust
- Identify what an unhealthy relationship looks like
- Provide an opportunity for youth to seek help when needed

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Inform youth that there are many ways to think about whether a relationship is healthy or unhealthy and that these things are not always obvious. The model presented in this handout is most helpful for understanding actions and comments that may be unhealthy in a sneaky or less explicit way.

Show the handout to the youth and explain that there are four criteria that determine if a relationship is caring and loving (healthy) or hurtful (unhealthy): respect, equality, safety, and trust. The handout sometimes refers to these as “R.E.S.T.”

Explain that all relationships have each of these four criteria. They can be part of what makes a relationship strong and sturdy (a column) or they can be part of what makes a relationship empty, hurtful, or unsafe, or undermines a person’s sense of self-worth (a shadow). Some shadows are very clearly shadows, like when a partner screams, calls names, or hits their partner. However, some shadows may appear to be columns, meaning that they appear “healthy” until you think more deeply about them.

For example, a partner may say, “I know you don’t like PDA, but I just love you so much that I have to kiss you,” or “I would respect you more if you wore different clothes.” These statements are unhealthy shadows of safety and of respect, respectively.

Read through the bottom two boxes on the handout with the youth, “A Healthy Column of R.E.S.T.” and “An Unhealthy Shadow of R.E.S.T.” Then ask the youth to provide you some examples of each of the four criteria that would be healthy and unhealthy. Or you can provide four shadow examples to the youth and ask them to rephrase each one into a column.

Some shadow examples include:

- **Respect:** “I need to drive because we both know you can’t keep us safe.”
- **Equality:** “I have better taste in food than you, so I think it’s best that I pick where we eat.”
- **Safety:** “I would know that you truly loved me if you had sex with me.”
- **Trust:** “I could trust you more if you would give me your account passwords.”

Examples of how these shadows could be rephrased as columns are:

- **Respect:** “I am sometimes worried when you drive. Maybe we could walk or take the bus?”
- **Equality:** “I know we like different kinds of foods, so let’s talk about the places where we each like to eat so we can find the places we both like.”
- **Safety:** “Sex is one way to show love, but it’s not the only way. How do you like to show me your love?”
- **Trust:** “I trust you.”

This activity has the potential to illicit trauma cues in different ways. For example, if a youth has experienced an abusive relationship, this may remind them of what that felt like. If so, validate the youth’s experiences by listening to their feelings, letting them know it is not their fault, and that many people experience intimate partner violence. They may also have not had the safety and opportunity to discuss this in the past, so this may be new to them.

### ***Counselors***

You can further process youth’s past experience of intimate partner violence by asking what motivated them to leave the relationship. Help youth recognize their own resilience by reflecting how it must have been scary to leave the relationship and how brave the youth was for doing so. Counselors can also explore how a youth’s strengths have kept them strong throughout the healing process. Alternatively, this activity could help a youth realize they are currently in an unhealthy relationship, which could be a first step toward positive action. If so, proceed by creating a safety plan with the youth. Do not pressure or coerce the youth into leaving the relationship. Instead, meet the youth where they are emotionally.

Professionals with limited time can use popular culture to provide examples of shadows and columns to youth. Explore with youth what it means to feel respect, equality, safety, and trust. Explore how one’s intuition or gut feelings might play a role when assessing R.E.S.T. in a relationship.

**Note:** If a youth does decide to leave an abusive relationship, talk about the fact that the moment of breaking up can be the most dangerous moment in an abusive relationship. Make sure they know how to access the local sexual assault and domestic violence centers and have numbers for support hotlines.

## Group Conversations

Break up a large group into smaller groups of three or four youth. Have each small group create a story about two people in an unhealthy, but not explicitly abusive, relationship. Encourage group members to assign clear examples of shadow statements when characterizing the unhealthy relationship. Next, ask the groups to rewrite the shadow statements so that they are columns. Discuss the ways in which the columns are supportive and the shadows are not.

Write a safety plan for a person who wants to leave an abusive relationship. This safety plan should connect back to the shadows present in the unhealthy relationship and should include a Plan A and Plan B in case the person experiences challenges along the way. Debrief with the group about feelings toward the exercise. Ask the group how likely they would be to share concerns about a friend's relationship. You can also explore how comfortable group members would be in enacting this safety plan.

## A Suggested Wrap-Up

Ask the youth if they have any questions about the handout or the information. Allow them time to process any thoughts, feelings, and questions they may have. Some possible questions you could ask the youth include:

- How has this exercise changed your perspective on healthy relationships?
- What other columns/shadows are important to you when determining if a relationship is healthy or not?
- What information surprised you today?

# Columns and Shadows: A Healthy Relationship Model

## A Healthy Relationship is Shaped by **RESPECT, EQUALITY, SAFETY, & TRUST**

Behaviors & attitudes that fall into one of these categories can appear in one of two ways: as columns (sturdy, reliable, yay!) or shadows (empty, shifty, not yay.).



HOW TO KNOW?! Well, A Behavior or Attitude is PROBABLY...

- a **HEALTHY COLUMN** of R.E.S.T. if
- ☺ it's presented without condition, exception, or pressure, and
  - ☺ you can respond or act in a way you are comfortable with.

- an **UNHEALTHY SHADOW** of R.E.S.T. if
- ☹ it's only presented with conditions, exceptions, or pressure, and
  - ☹ it requires you to act or respond in a way you are uncomfortable with.

## Communication Styles

Communication is a critical component of healthy relationships and can be explored with youth of all ages. Many people are not well versed in the different communication styles, including what they are, their definitions, the one they use the most, or the one that would best support themselves, their partner, their sexual health, and their relationship. When they do have all this information, they are much more likely to interact in positive, healthy ways with their sexual and romantic partners. This handout facilitates dialogue about issues relating to four of the most common communication styles.

Note: Be aware that youth in foster care may not have had any role models for assertive relationships. In fact, being assertive in an abusive, violent, or harsh environment may actually be dangerous. Under specific circumstances, passive or aggressive responses may have been a necessary way to adapt, even if they become a problem for future, healthy relationships.

### Objectives

- Understand the four communication styles
- Examine the potential impact of communication styles on relationships
- Promote assertive communication as a way to create healthier relationships
- Brainstorm ways one can help make their communication style more assertive

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

You can use this handout to inform youth there are four communication styles most frequently used in relationships, and three of them are primarily unhealthy. Write the names of the four types of communication on a piece of paper and look at them with the youth. Invite the youth to describe, to the best of their ability, examples of each of the communication styles below. Use the following definitions to support the youth's process.

#### *Counselors*

You can further apply the exercise to relationships in the youth's life, such as a relationship with a peer or the relationship between the youth's parents. The counselor could encourage discussion about how two people with two different communication styles might interact with one another—as well as the consequences that this interaction might have on their relationship with each other and with other people. It is important to help the youth recognize that people who use aggressive, passive-aggressive, or passive communication styles might have learned to communicate that way as a means of survival in the past. Encourage youth to think of different ways in which assertive communication can foster healthier relationships with safe people. Help youth come up with strategies to develop a healthier communication style. In a safe group environment, role-play can be a great way to learn about healthier communication dynamics.

## Individual Conversations

### ***Mix and Match***

This activity can be introduced in many ways. You can play it as a game by cutting out cards from each of the four communication styles handouts, mixing them up in a pile, and inviting the youth to select a card and guess which type of communication it is associated with. You can also use the activity strictly as a discussion topic by reading through the examples with a youth and discussing why they fall into each category. This activity could also be used as a role-play, depending on the youth's comfort level. Explain to the youth that the tone of the person speaking can cause the style of communication to change even when the words are the same. Encourage the youth to practice saying different examples in different speaking tones.

This activity can also be done in group settings. Group members can brainstorm additional examples of different communication styles and anonymously write them down on index cards. Then group members can work together to decide which communication style each example represents. Encourage group members to explore the reasoning behind their decisions. Additionally, have group members take turns experimenting with pitch, tone, or body language while the rest of the group provides feedback about how the group member was perceived and their own physiological reactions. Explore the implications of these subtle forms of communication in group members' relationships.

Be mindful that youth might have heard some of these phrases from other people in their life. Youth might experience strong emotions or physiological responses to this activity, especially when exploring aggressive communication. This could be due to past experiences or attuning to the energy in the room. Therefore, it would be beneficial to explore all four communication styles as a mix of topics instead of focusing on one style at a time. Use a grounding or mindfulness activity when ending the session to help soothe dysregulated group members.

## Additional Information

- **Aggressive:** This communication style involves attacking other people and being controlling. A person who communicates in this style expresses only their own thoughts and feelings without allowing others to do so. They may yell or become physical during the conversation. This person may make demands of others, speak over people, and put people down to feel better about themselves and further their own desires.
- **Passive-aggressive:** This communication style involves not directly relating to people, not accepting what is happening, and indirectly retaliating. This type of communication can cause confusion and frustration. It is about not accepting responsibility for what you are saying by being aggressive in a passive manner. The receiver of this type of communication may feel "stung," but might not be exactly sure how or why. Meanwhile, the speaker can act as though they have done nothing wrong or hurtful.

- **Passive:** This communication style involves the speaker withdrawing, becoming anxious, and avoiding confrontation. People who communicate with this style will allow others to speak for them, make decisions for them, and tell them what to do while suppressing their own thoughts and feelings.
- **Assertive:** This communication style is about knowing what you feel and what you want. Assertive communication is characterized by someone expressing their true feelings and asking for what they want without violating the rights of others. People practicing this style of communication accept responsibility for their own feelings and actions and allow others to share their thoughts and feelings without interruption or criticism. Assertive communication also includes “I” statements, rather than “You” statements, and the speaker focuses on what they want rather than what the other person should do for them.

Assertive communication is the healthiest style of the four because it:

- Respects other people’s feelings, thoughts, and right to speak. It does not attempt to overpower them.
- Respects a person’s own feelings, thoughts, and right to speak.
- Uses “I” statements instead of “You” statements.

Assertive communication is about honesty and integrity and respecting yourself and those around you. It is important to understand that using “I” statements does not mean that you can never use the word “you.” Take the statements below as examples:

- “I feel sad and hurt when you call me names. I would appreciate it if you would stop.”
- “I think that the first Star Wars movie is the best because of the quality of acting. I would love to hear more about your opinion.”
- “You’re right, I am very sorry and feel ashamed. I shouldn’t have called your idea stupid. It was mean and disrespectful, and I didn’t take your feelings into consideration. I hope that you can forgive me.”

The above statements are assertive because they state personal feelings and thoughts, respect the other person in the conversation, identify what the person did or needs, and provide an inviting environment for the other person to respond.

While a person can choose to communicate assertively, they cannot control the other person’s response. While assertive communication can shift unhealthy dynamics and is the foundation for a strong relationship, an abusive partner may continue to be abusive even when their partner is trying to shift toward a healthier communication dynamic.

## A Suggested Wrap-Up

Ask the youth if they have any questions about the handout or the information. Allow them time to process any thoughts, feelings, and questions they may have. Some possible questions you could ask the youth include:

- Which of the communication styles do you hear in your day-to-day life?
- Who communicates most frequently in each of the four styles? How do their communication styles impact your responses to them?
- When do you most frequently use each of the four communication styles?
- Encourage the youth to pay attention to which style people respond to most positively.

## Passive Communication Style Prompt Slips

|                                                                                                                                                                 |                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <br>Is afraid to speak up                                                      | <br>Avoids looking at people                                                                                           |
| <br>“I’m allergic to seafood,<br>but I’m sure I can find<br>something to eat.” | <br>When asked to go see a<br>movie they don’t want<br>to see they respond,<br>“Sure, I’m sure it is a good<br>movie.” |
| <br>Agrees with other people<br>despite their own feelings                   |                                                                                                                                                                                                         |

## Passive-Aggressive Communication Style Prompt Slips

“Fine, whatever!”

“Let me clarify, because  
I’m sure you didn’t  
understand.”

“I was only joking, wow!”

“I wanted to do something  
nice for you, but never  
mind.”

“You’ve done so well for  
someone like you.”

## Aggressive Communication Style Prompt Slips



“This is what we’re doing.  
If you don’t like it, tough.”



“Get out of my way!  
You’re always in the  
wrong place!”



“Stop talking! I’ll let you  
know when you can speak  
again.”



Interrupts and “talks over”  
people.



Only considers their  
own feelings and makes  
demands of others.

## Assertive Communication Style Prompt Slips

 “I feel like going out to eat tonight. Let’s pick a place we will both enjoy.”

 “I feel sad when you call me names, I would like you to stop.”

 Values self and other people.

 Uses “I” instead of “You” statements.

 “Thank you for telling me what you want. I feel happy when we communicate openly.”

## Condoms, for Fact's Sake!

Many people assume putting on a condom is easy, that it is simple and intuitive. But if this were the case, far fewer unintended pregnancies would happen and far fewer STIs would be transmitted. The reality is that external condoms are 98% effective with perfect use, but only 85% effective with typical use (Planned Parenthood, n.d.).

This simple step-by-step instruction guide is designed to support youth in reaching that 98% effectiveness when they use condoms. Going over the steps of how to use a condom is always worth the time when you have a youth who is using them for either STI protection or for pregnancy prevention.

Knowing how to access and use condoms does not encourage people (of any age) to have sex—rather it encourages them to be aware of their sexual health-related options and increases their skills in accessing and using those options.

For people with latex allergies, it is important to note that condoms come in various materials, not just latex. Ask your youth if they have a latex allergy.

If you are working with an underage youth, be sure to check your state laws and agency policies before showing them or talking about this handout.

### Objectives

- Inform youth on the proper way to use a condom
- Deconstruct stigma related to condom use, condom size, and pleasure
- Promote safer sex by normalizing condom use

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

You should normalize the content and process presented in this handout as much as possible. Reflect on how culture might influence youth's perspective on condom use. It is important to be aware of the messages you are sending to youth when talking about condoms. Do not shame youth by showing disgust toward people who have condomless sex. Using shameful language will further stigmatize youth who have experienced sexual assault, contracted an STI, or are pregnant or parenting.

Gently let youth know that many people think they know how to put on a condom but sometimes they are unaware of the details. Knowing that you are doing it right is the best way to assure safer sex. After going over each part of the handout, ask your youth if any step or information was new or surprised them. Even after you discuss the steps it is important to normalize and remove judgment from your conversation.

It is likely that the youth will have questions concerning condoms other than how to put one on. Additional questions may include the following (adapted from Rayne and Smarr, 2017):

- **Can you feel anything through a condom?** Yes, you can. There are many activities a youth can do alone or with a partner to demonstrate this. For example, have the youth place a condom over their fingers, close their eyes, and blow on it, touch it with their finger, and even gently touch it with a feather. Each scenario is likely to cause the youth to feel the touch.
- **Is the condom too small?** Suggest that the youth explore the size their condom can become. This is an activity they can do alone, with a partner, or even with a family. They can stretch the condom, pull it with their hands and feet, blow it up, and make it larger in any other way. It is important to know that condoms can expand to different sizes and that condoms can be purchased in different sizes to be comfortable. There are even companies that make condoms for specific measurements.

If time permits, explore the youth's beliefs about condom use. Ask them why they think there is a difference between the effectiveness of perfect condom use and typical condom use. This might create an opportunity to work with youth on how to overcome challenges related to typical condom usage. For example, youth might share that they are less likely to use a condom if their partner refuses. The counselor might then decide to support the youth's communication skills through role-play to promote sexual health.

## Group Conversations

Explain the handout to the group members. Collaborate on strategies to address and overcome their own and their partners' perceived challenges about using condoms. This might lead to role-playing scenarios to help group members communicate their sexual health needs to their partner. Encourage group members to discuss how condoms can promote sexual health for them and their partner.

## A Suggested Wrap-Up

Acknowledge that it is easy to be worried for lots of reasons before having sex. However, concerns and worries don't mean that the youth should not take care of their sexual health by not using condoms. Encourage the youth to get more comfortable with condoms by opening and getting familiar with one on their own before using one with a partner. For youth who have a penis, practicing putting on a condom when they are alone can help them be more confident in the process with a partner. Feeling uncomfortable putting a condom on can be a roadblock to using one during sex. Exploring and breaking down one's own perspectives about condoms can release some of these fears and worries.

# Condoms

## For fact's sake!



What is a condom?

There are **2** types of  
condoms



### Internal:

A barrier method of protection that can be inserted into the vagina or anus.

Perfect use = **95%**  
effective

Typical use is 79% effective



### External:

A barrier method of protection that is placed on the penis.

Perfect use = **98%**  
effective

Typical use is 82% effective

Barrier methods of protection can prevent pregnancy and the transmission of some sexually transmitted infections.

### Tips for use



Before putting on a condom, put a few drops of water- or silicone-based lube inside the condom. Do not use oil-based lube, as this will weaken and sometimes break the condom.



Store condoms in a cool, dry, dark place out of direct sunlight. Don't carry them freely in your wallet or pocket where they might get bent or punctured.



Always use a new condom for every sexual activity. If you are switching from a vagina to an anus, for example, you should use a different condom when you switch. Never reuse a condom.

### How to use an external condom

**STEP 1** Make sure you have a nonexpired condom.



**STEP 2** Tear the package through the perforated edges and remove the condom from the package. Never use scissors.



**STEP 3** Check that the condom is right-side-out and can be rolled down from the outside.

Gently squeeze the tip of the condom to leave about 3/4" of space for ejaculate.



**STEP 4** Place the condom on the head of the erect penis before any genital contact.

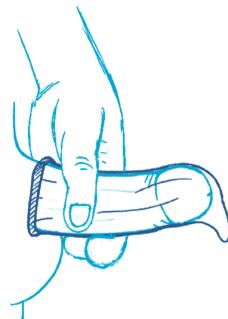


Roll the condom down to the base of the penis.

If it will not roll down, it is inside-out. Throw that condom away and use a fresh one, as it can have pre-ejaculate on it.

**STEP 5** After ejaculation, hold the condom on the base of the penis. Withdraw the penis from the partner's body before it becomes flaccid.

Throw the condom away in the trash. Do not try to wash and re-use it. Do not flush it down the toilet.



## Notes

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## Consent

Consent is being discussed a lot in the media, in the government, on school campuses, and just about everywhere else in the wake of the #metoo movement and massive sexual harassment and assault scandals.

This handout discusses two of the ways in which consent is often described: “no means no” (although this is a slightly outdated framework) and “yes means yes” (also described as enthusiastic consent). The two handouts on consent, “No Means No” and “Yes Means Yes,” should be used together so that both frameworks are included in the conversation. Both handouts provide very simplified perspectives on consent. These handouts are meant to begin a conversation on consent, not to be considered the final word on consent.

Be aware that youth involved in the child welfare system are likely to have had experiences in which their consent was disregarded or compromised. This will influence their perspective of consent and what they decide to share with you. Begin your conversation by reminding them of the limits of your ability to keep disclosures confidential and the applicable mandatory reporting laws.

Stay calm if youth disclose sexual abuse or an assault. It may be necessary to speak with other personnel, police, or child protective services if the disclosure presents new information and the youth would like to make a report. If so, empower youth by walking them through the process and providing them with choice and autonomy when available. Caregivers, direct care staff, case managers, and counselors should promote the use of coping strategies if youth become overwhelmed. It is recommended that a counselor facilitate this exercise when working with youth in child welfare. However, suggestions are provided for caregivers, and case managers interested in promoting consent.

Dr. Karen Rayne developed these handouts to introduce consent to young adolescents, but they can be used and discussed with youth of any age, by parents or other caring adults who want to speak about consent with the young people in their lives.

### Objectives

- Encourage youth to think critically about consent
- Normalize the concept of consent and choice
- Create strategies to invite conversations with intimate partners about their personal boundaries
- Create strategies to reinforce personal boundaries with intimate partners
- Respect when a partner says “no” to a sexual activity

### Individual Conversations

Make sure you are familiar with each handout and the scenario they present before providing the handouts to youth. Remember, these handouts are more about the discussion about what consent is, rather than about you providing the youth with a definitive answer.

### ***Caregivers***

Ask the youth what they think about when they hear the word consent. Discuss and process the youth's answer. Explain to the youth that consent is more complicated than people often think it is. Share the handouts with the youth and discuss the scenario in terms of the two definitions. Discuss with the youth whether they think the definition is useful and complete, or not. Point out that communication is the biggest piece of consent, yet the concept is rarely discussed in those terms. Of course, communication isn't the only aspect of consent, but it is what allows consent (or a withholding or withdrawal of consent) to happen.

You can also encourage youth to continue to explore their ideas of consent through discussing examples from the media and news based on the two handout definitions. Movies, television shows, song lyrics, and books all provide ample examples to draw from in conversations about consent (although they are rarely positive examples). These issues are also frequently considered in reaction to events shared in the news. Continued discussion is always needed.

In child welfare, youth can feel like they do not have much choice when it comes to where they sleep at night, the rules there, and when they are allowed to see their family and friends. Look for opportunities for youth to practice choice and consent in everyday life. For caregivers, this might look like asking for permission before hugging youth or entering their bedroom when checking in with them. It is important to empower youth by respecting their decision if they say no. Sometimes, it can be helpful to explore with youth what is needed to make them feel more comfortable about a situation such as attending a social event or going to a visitation. Listen to youth and consider how you can best advocate for them in these situations.

### ***Counselors***

Discuss consent further through deeper dialogue about the youth's personal experiences and how they may feel about them given the two definitions of consent and their own ideas about whether those definitions are useful and complete.

When a youth indicates a violation or compromise of consent in the scenario in the handout, encourage them to think of ways to communicate the violation and how to reinforce boundaries with partners. Explore how gut feelings, peer pressure, and other factors can influence the nuances of consent.

## **Group Conversations**

Complete the exercise in a group setting by having group members openly discuss the scenario while using both the "no means no" and "yes means yes" frameworks. The primary benefit of this activity is not in the handouts, but in the discussion that happens after them. Explore how someone's understanding of consent changes depending on which framework is used. The group leader can also reflect on how perceptions of consent differ among people with the following discussion questions:

- How could you ask someone to consent to a sexual activity with you in a way that doesn't feel awkward or uncomfortable?

- How can you make it clear to a partner that you don't want to continue a sexual activity?
- Why would someone engage in sex even if they didn't want to? (Example answers: the person may be afraid to jeopardize the relationship, feeling obligated or indebted, feel pressured, want to avoid tension, be afraid the partner might lose interest, doesn't want to hurt partner's feelings, or be afraid to say no.)
- How do you know when you're pressuring someone to have sex?
- What are some excuses you have used or heard to justify pressuring someone for sex?

## A Suggested Wrap-Up

When you have discussed and processed each handout, additional questions you could ask may include:

- What differences did you notice between the handouts?
- Did you feel there was anything missing from either of these ideas of consent?
- How can you check in with a partner when you are not sure whether they want to go further? (Example answers: "Are you good? Does this still feel okay?" "You seem quiet. Are you okay?") What should you do if you check in and a partner doesn't answer or answers very quietly?

You can encourage all youth to keep a journal with thoughts on consent and how they see it represented in the media. This will allow them to formulate their own concept of consent and to become more media literate.

## **Consent, Part 1: “No Means No”**

This idea of consent says that unless someone says no to doing something, they have consented to it. Think about what that might mean in this example:

Blair and Chris went to get tacos on their first date. Blair reached over to hold Chris’s hand and they held hands for a long time while they ate. When the conversation slowed down, Blair leaned over and kissed Chris. Chris didn’t say anything either time.

Using only the “no means no” idea of consent, answer the following questions about this scenario:

- Did Blair consent to holding Chris’s hand? How do you know?
- Did Chris consent to holding Blair’s hand? How do you know?
- Did Blair consent to kissing Chris? How do you know?
- Did Chris consent to kissing Blair? How do you know?

## **Consent, Part 2: “Yes Means Yes”**

This idea of consent says that only when someone says yes to doing something have they consented to it. Think about what that might mean in this example:

Blair and Chris went to get tacos on their first date. Blair reached over to hold Chris’s hand and they held hands for a long time while they ate. When the conversation slowed down, Blair leaned over and kissed Chris. Chris didn’t say anything either time.

Using only the “yes means yes” idea of consent, answer the following questions about this scenario:

- Did Blair consent to holding Chris’s hand? How do you know?
  
- Did Chris consent to holding Blair’s hand? How do you know?
  
- Did Blair consent to kissing Chris? How do you know?
  
- Did Chris consent to kissing Blair? How do you know?

## Notes

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## Contraceptives

This handout was developed by Dr. Rayne and Jessica Smarr, MPH, to be used in *UN/HUSHED: The Middle School Curriculum*. This detailed handout is helpful to use with youth who are interested in starting or changing contraception, a youth (or caregiver) confused about contraceptives, and other educational purposes. To be prepared to discuss the four types of contraceptives—surgical, hormonal, behavioral, and barrier—refer back to the subsection on contraceptives in “All About Sexuality.”

Youth in child welfare may have previously resided in placements that mandated contraception even if they were not sexually active. So it is understandable that some youth might have negative reactions to birth control. Moreover, youth might have experienced reproductive coercion from a sexual partner or family member. Due to these experiences, youth might feel a lack of control over their bodies. Therefore, this topic should be discussed with a lot of sensitivity.

Youth should never feel pressured or forced to use contraception. Whenever possible provide youth with a sense of control over their bodies by emphasizing autonomy. Let youth know that your role is to give them information so that they can make informed decisions about their body and contraception. Tell youth that no one should ever force them to take contraception or stop them from having access to it.

### Objectives

- Provide youth with information about contraception
- Inform youth of contraceptive options that prevent STIs
- Promote bodily autonomy
- Revisit the conception process

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Ask the youth what contraceptive or birth control methods they already know about. Many may know about the pill due to its popularity and exposure in popular media. Some may also mention condoms, although many people think of condoms as an STI-prevention method rather than birth control (although condoms do both). Let the youth know that there are many types of contraceptives that meet different couples’ needs. Each method has pros and cons and various degrees of effectiveness.

Before providing the youth with the handout, review the process of conception with them: The most common way for conception to occur is by sperm leaving the testicles and penis and entering the uterus through the vagina. It then must make its way up a fallopian tube and wait to see if there is an egg to fertilize. Remind participants that there will only be an egg to fertilize if ovulation, or the release of a mature egg from the ovary into the fallopian tube, occurs. (There are a range of other ways for conception to occur through medical interventions.)

Provide the handout to the youth and review how the four types of contraceptives work. Many youth will have additional questions, so be sure to read the safer sex subsection in “All About Sexuality” in order to answer those questions. If there are time limitations, then you can always provide the handout to the youth and follow up with them when more time is available.

It is important to not shame youth who are disinterested in contraception. Forcing youth to use contraception can cause resistance and give them a negative feeling toward contraception. Instead respect the youth’s decision and inform them that you are always here to talk about this topic further if they would like to. Alternatively, you can explore the reasoning behind their decision and ask what would need to change or happen for them to feel more comfortable using contraception. The information gained can be helpful for youth who might be unsure or ambivalent about contraception.

## About STI Prevention

It is imperative that youth understand that most contraceptives do not prevent STIs. Address this common misconception with them, noting that internal and external condoms are the only contraceptive methods that prevent STIs.

## Group Conversations

It is encouraged to talk about the conception process again with group members before going over the handout. Afterward, have group members work together to list the pros, cons, and level of STI or pregnancy risk associated with various contraceptive methods. It can be helpful to acquire models of different types of birth control such as IUDs, the ring, and both internal and external condoms. These models can be passed around amongst group members.

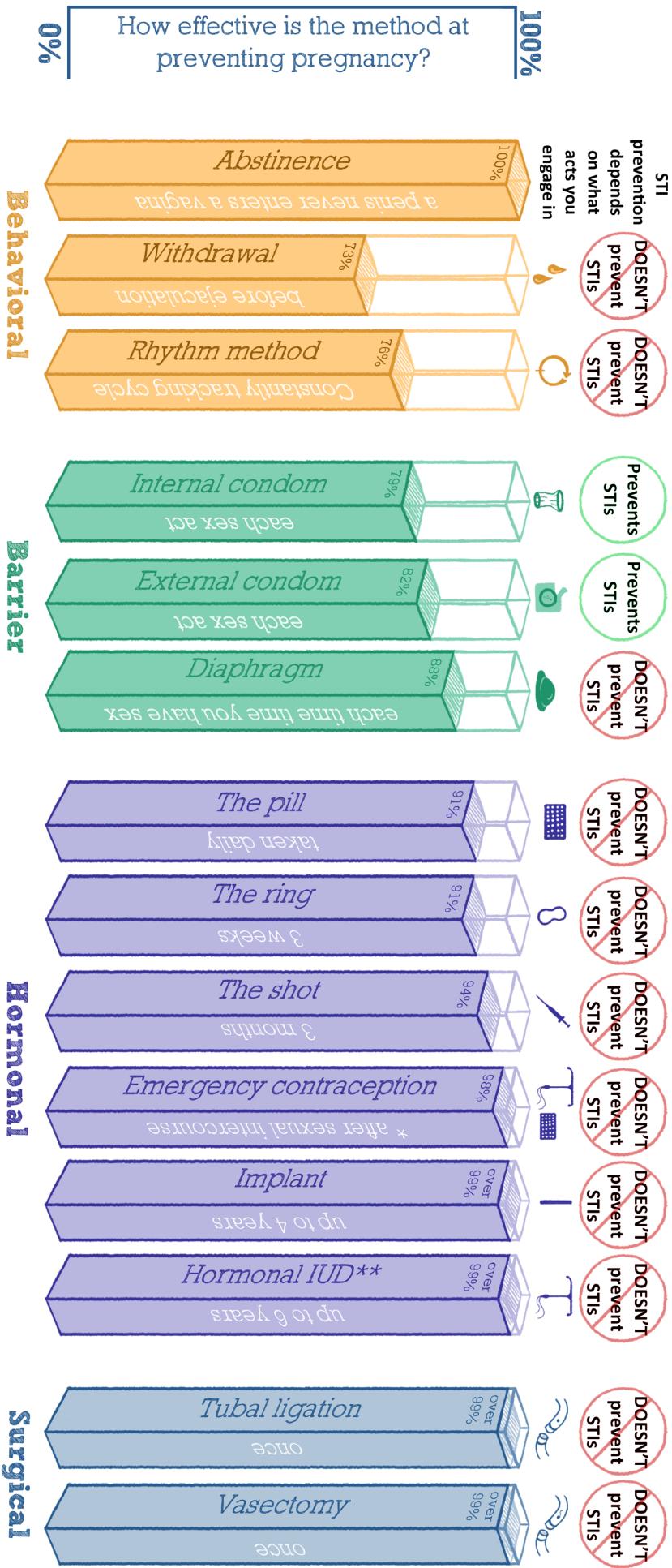
Ask group members what is important to them when deciding what contraception to use. Reflect back to the group any similarities or differences amongst members to exemplify how various types of contraception have been created to meet everyone’s unique preferences. Group leaders can also explore group members’ past experiences with contraception, especially regarding strengths and challenges associated with a particular contraception method. Give space to group members who use this topic as an opportunity to vent about their experiences and frustrations with contraception being predominantly the responsibility of the person with female anatomy. Allow time to clarify any questions youth might have or offer to do research and follow up with them later about their question.

## A Suggested Wrap-Up

Encourage the youth to take the handout home with them and otherwise ensure that they have access to accurate information, including medical professionals to speak with, and are not merely googling for answers. If you are working with a minor, and it is safe to do so, discuss the need for contraception with caregivers prior to the session and encourage a family conversation as a joint homework assignment. Note that some states require parental permission for teenagers to access hormonal contraception. Condoms are available to anyone of any age across the entire United States.

# Contraceptives

Handout from *An Introduction to Sexuality Education: A Handbook for Childwelfare Providers* © 2021 by UN|HUSHED. All rights reserved.



Dual Method is any two, usually a barrier + a hormonal = 92% to over 99% effectiveness

- \* Individual should begin taking pills or have the IUD inserted as soon as possible, for up to 5 days after having unprotected sex.
- \*\* There is also a nonhormonal version of this method of birth control that lasts up to 12 years.

References for the contraceptive handout:  
<https://www.plannedparenthood.org/learn/birth-control>  
<https://www.cdc.gov/reproductivehealth/contraception/>  
<http://bit.ly/unhushed-scarletteen>

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## Notes

## Declaration of Sexual Rights

The World Association for Sexual Health (WAS) created an in-depth list of sexual rights in 1997, and has since updated it twice, most recently in 2014. The Declaration of Sexual Rights was created to expand the global understanding of what is possible and what is necessary to support all people's basic sexual rights.

This document is great to use for yourself as a professional, and for the youth you work with who may be struggling with their sexuality and sexual health. The Declaration of Sexual Rights can be particularly powerful for youth who don't believe that they can, or even should, have access to sexual pleasure or any of the other rights included in the declaration. You can frame these sixteen concepts as something that an important, respected global organization believes should be considered inalienable, or inherent, to all people. This is dramatically different from many people's individual experiences of their own sexual rights.

### Objectives

- Inform youth about the Declaration of Sexual Rights
- Encourage youth to think critically about their own rights
- Empower youth to advocate for sexual health

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Ask youth if they have ever considered whether they—or anyone else—have sexual rights. You can point out that in the United States, everyone is supposed to have rights such as freedom of speech. Ask the youth if they know of any other rights that everyone in the United States is supposed to have. (Look at [www.billofrights.org](http://www.billofrights.org) for a refresher.) Note that none of these rights, however, are about sex or sexuality. Ask the youth if they can think of a sex- or sexuality-related right that they believe everyone should have. If they have ideas for more than one important right about sex or sexuality, write them out together.

Introduce the youth to the World Association for Sexual Health as a leading organization that promotes sexual health around the world by developing and supporting sexology and sexual rights for all. Let them know that WAS created a Declaration of Sexual Rights and review the declaration with the youth. Talk about each of the rights, making sure they understand the language. If you know there are particular rights the youth struggles to see themselves as deserving, make sure to discuss them in more depth and then process their thoughts and feelings.

#### *Counselors*

Explore what a violation of sexual rights feels like and how to best proceed afterward. Give youth space to process complicated feelings, especially if the justice system did not affirm the youth's sexual rights

if they pressed charges. Validate youth who feel that society does not recognize their sexual rights due to able-bodiedness, age, class, gender, race, sex, sexual orientation, or other identity-related elements of themselves.

## **Group Conversations**

Tell the group about WAS and how it takes a strong stance on sexual and reproductive health and rights and advocates for change on a global level. One way WAS advocates for sexual health is by creating tools like the Declaration of Sexual Rights to help communities know their sexual rights and to help make a difference on a local level.

Review the declaration with the group and discuss why it is important to know your rights. Ask group members to share if they feel strongly or indifferent about any of the rights. Empower group members to advocate for a sexual health right that they feel strongly about. Brainstorm ways group members can make a change, such as awareness campaigns using social media or even speaking with a legislator. Follow up with youth at the next session to learn how the experience was for them. Alternatively, if there is good group cohesion, you can encourage group members to work collectively on a project to increase their own or others' access to sexual rights as defined and described by WAS.

## **Additional Information**

For a more substantial guide on using the WAS Declaration of Sexual Rights (including a copy in Spanish), see Kismodi, Corona, Maticka-Tyndale, Rubio-Aurioles, and Coleman (2017).

## **Suggested Wrap-Up**

Ask youth how knowing their sexual rights can help them make informed decisions about their sexual health.

If youth are interested in raising awareness and advocating for sexual health, help them identify how they can best achieve their goal. Provide helpful resources and people for youth to talk to so they can learn more about how they can enact change. This can be a great way to strengthen youth's confidence and support system.

# Declaration of Sexual Rights



WORLD ASSOCIATION FOR SEXUAL HEALTH



## DECLARATION OF SEXUAL RIGHTS

In recognition that sexual rights are essential for the achievement of the highest attainable sexual health, the World Association for Sexual Health:

**STATES** that sexual rights are grounded in universal human rights that are already recognized in international and regional human rights documents, in national constitutions and laws, human rights standards and principles, and in scientific knowledge related to human sexuality and sexual health.

**REAFFIRMS** that sexuality is a central aspect of being human throughout life, encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.

**RECOGNIZES** that sexuality is a source of pleasure and wellbeing and contributes to overall fulfillment and satisfaction.

**REAFFIRMS** that sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

**REAFFIRMS** that sexual health cannot be defined, understood or made operational without a broad understanding of sexuality.

**REAFFIRMS** that for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

**RECOGNIZES** that sexual rights are based on the inherent freedom, dignity, and equality of all human beings and include a commitment to protection from harm.

**STATES** that equality and non-discrimination are foundational to all human rights protection and promotion and include the prohibition of any distinction, exclusion or restriction on the basis of race, ethnicity, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, including disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation.

**RECOGNIZES** that persons' sexual orientations, gender identities, gender expressions and bodily diversities require human rights protection.

**RECOGNIZES** that all types of violence, harassment, discrimination, exclusion, and stigmatization are violations of human rights, and impact the wellbeing of individuals, families and communities.

**AFFIRMS** that the obligations to respect, protect and fulfill human rights apply to all sexual rights and freedoms.

**AFFIRMS** that sexual rights protect all people's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others.

## Declaration of Sexual Rights (cont'd)



SEXUAL RIGHTS ARE HUMAN RIGHTS PERTAINING TO SEXUALITY

- 1 The right to equality and non-discrimination**  
Everyone is entitled to enjoy all sexual rights set forth in this Declaration without distinction of any kind such as race, ethnicity, color, sex, language, religion, political or other opinion, national or social origin, place of residence, property, birth, disability, age, nationality, marital and family status, sexual orientation, gender identity and expression, health status, economic and social situation and other status.
- 2 The right to life, liberty, and security of the person**  
Everyone has the right to life, liberty, and security that cannot be arbitrarily threatened, limited, or taken away for reasons related to sexuality. These include: sexual orientation, consensual sexual behavior and practices, gender identity and expression, or because of accessing or providing services related to sexual and reproductive health.
- 3 The right to autonomy and bodily integrity**  
Everyone has the right to control and decide freely on matters related to their sexuality and their body. This includes the choice of sexual behaviors, practices, partners and relationships with due regard to the rights of others. Free and informed decision making requires free and informed consent prior to any sexually-related testing, interventions, therapies, surgeries, or research.
- 4 The right to be free from torture and cruel, inhuman, or degrading treatment or punishment.**  
Everyone shall be free from torture and cruel, inhuman, or degrading treatment or punishment related to sexuality, including: harmful traditional practices; forced sterilization, contraception, or abortion; and other forms of torture, cruel, inhuman, or degrading treatment perpetrated for reasons related to someone's sex, gender, sexual orientation, gender identity and expression, and bodily diversity.
- 5 The right to be free from all forms of violence and coercion**  
Everyone shall be free from sexuality related violence and coercion, including: rape, sexual abuse, sexual harassment, bullying, sexual exploitation and slavery, trafficking for purposes of sexual exploitation, virginity testing, and violence committed because of real or perceived sexual practices, sexual orientation, gender identity and expression, and bodily diversity.
- 6 The right to privacy**  
Everyone has the right to privacy related to sexuality, sexual life, and choices regarding their own body and consensual sexual relations and practices without arbitrary interference and intrusion. This includes the right to control the disclosure of sexuality-related personal information to others.
- 7 The right to the highest attainable standard of health, including sexual health; with the possibility of pleasurable, satisfying, and safe sexual experiences**  
Everyone has the right to the highest attainable level of health and wellbeing in relation to sexuality, including the possibility of pleasurable, satisfying, and safe sexual experiences. This requires the availability, accessibility, acceptability of quality health services and access to the conditions that influence and determine health including sexual health.
- 8 The right to enjoy the benefits of scientific progress and its application**  
Everyone has the right to enjoy the benefits of scientific progress and its applications in relation to sexuality and sexual health.
- 9 The right to information**  
Everyone shall have access to scientifically accurate and understandable information related to sexuality, sexual health, and sexual rights through diverse sources. Such information should not be arbitrarily censored, withheld, or intentionally misrepresented.

## Declaration of Sexual Rights (cont'd)



WORLD ASSOCIATION FOR SEXUAL HEALTH



### DECLARATION OF SEXUAL RIGHTS

#### 10 The right to education and the right to comprehensive sexuality education

Everyone has the right to education and comprehensive sexuality education. Comprehensive sexuality education must be age appropriate, scientifically accurate, culturally competent, and grounded in human rights, gender equality, and a positive approach to sexuality and pleasure.

#### 11 The right to enter, form, and dissolve marriage and other similar types of relationships based on equality and full and free consent

Everyone has the right to choose whether or not to marry and to enter freely and with full and free consent into marriage, partnership or other similar relationships. All persons are entitled to equal rights entering into, during, and at dissolution of marriage, partnership and other similar relationships, without discrimination or exclusion of any kind. This right includes equal entitlements to social welfare and other benefits regardless of the form of such relationships.

#### 12 The right to decide whether to have children, the number and spacing of children, and to have the information and the means to do so

Everyone has the right to decide whether to have children and the number and spacing of children. To exercise this right requires access to the conditions that influence and determine health and wellbeing, including sexual and reproductive health services related to pregnancy, contraception, fertility, pregnancy termination, and adoption.

#### 13 The right to the freedom of thought, opinion, and expression

Everyone has the right to freedom of thought, opinion, and expression regarding sexuality and has the right to express their own sexuality through, for example, appearance, communication, and behavior, with due respect to the rights of others.

#### 14 The right to freedom of association and peaceful assembly

Everyone has the right to peacefully organize, associate, assemble, demonstrate, and advocate including about sexuality, sexual health, and sexual rights.

#### 15 The right to participation in public and political life

Everyone is entitled to an environment that enables active, free, and meaningful participation in and contribution to the civil, economic, social, cultural, political, and other aspects of human life at local, national, regional, and international levels. In particular, all persons are entitled to participate in the development and implementation of policies that determine their welfare, including their sexuality and sexual health.

#### 16 The right to access to justice, remedies, and redress

Everyone has the right to access to justice, remedies, and redress for violations of their sexual rights. This requires effective, adequate, accessible, and appropriate educative, legislative, judicial, and other measures. Remedies include redress through restitution, compensation, rehabilitation, satisfaction, and guarantee of non-repetition.

The World Association for Sexual Health (WAS) is a multidisciplinary, world-wide group of scientific societies, NGOs and professionals in the field of human sexuality which promotes sexual health throughout the lifespan and through the world by developing, promoting and supporting sexology and sexual rights for all. WAS accomplishes this by advocacy actions, networking, facilitating the exchange of information, ideas and experiences and advancing scientifically based sexuality research, sexuality education and clinical sexology, with a trans-disciplinary approach. The WAS Declaration of Sexual Rights was originally proclaimed at the 13th World Congress of Sexology in Valencia, Spain in 1997 and then, in 1999, a revision was approved in Hong Kong by the WAS General Assembly and then reaffirmed in the WAS Declaration: Sexual Health for the Millennium (2008). This revised Declaration was approved Declaration by the WAS Advisory Council in March, 2014.

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## The Egg in the Reproduction Process

This handout shows the egg's progress in the process of ovulation, fertilization, and implantation. It was developed by Dr. Karen Rayne and Jessica Smarr, MPH, for *UN/HUSHED: The Middle School Curriculum* and can be used with youth of all ages to discuss these biological functions.

This handout can be used for different purposes, including educational or preventative reasons. Not knowing the details or misunderstanding this process can be detrimental to youth. Many people do not understand the reproduction process, which can lead to both physical and emotional issues. Unwanted pregnancy and family arguments are just two possible examples.

This information can be both useful and powerful for youth who are menstruating or are beginning to experiment sexually, for foster parents looking for information to provide to their children, for young couples or parents wanting to prevent or cause a pregnancy, and for youth who want to have a better understanding and sense of control over their own bodily functions. This handout can be used in both individual and group settings.

### Objectives

- Identify the stages between ovulation and the beginning of pregnancy
- Describe where in the ovary, fallopian tube, and uterus fertilization takes place

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Ask youth how relevant information about the egg in the reproductive process is to them rather than assuming how the youth will connect with it. For some people, especially cisgender heterosexual women, their personal connection to the information will be obvious to them. Others, like trans women who are exclusively sexual with cisgender men, may not actually need the information personally, and you may not be aware of that. However, it is possible that some youth, like cisgender heterosexual men, may not think they need this information when they actually do. Having this conversation will provide a safer space for youth who might find this information irrelevant or confusing due to being intersex, trans, or gay to explore their feelings. Professionals should encourage youth to reflect on how this information could affect their sexual health, especially in regard to safer sex and family planning.

Look at the handout together. Discuss the process of the egg in reproduction as outlined above. Discuss the point at which pregnancy begins and why people may hold different beliefs about the initiation of pregnancy.

## Group Conversations

Ask group members if they are familiar with the reproductive systems. Encourage youth to share their knowledge. If conflicting or inaccurate information comes up, then direct the conversation to how common it is for misinformation or myths to be passed around when it comes to this subject. Empower group members to think critically about historical, cultural, and societal reasons why misinformation persists. Then reconnect this back to the handout while reemphasizing the importance of learning about the reproductive system. Describe the process as outlined above as you go over the handout. Save time for questions at the end. Offer to find answers to questions that you are unsure of.

## Additional Information

It is important to verbally outline the specifics of the process of ovulation, fertilization, and implantation with this handout. Here are things to specifically include:

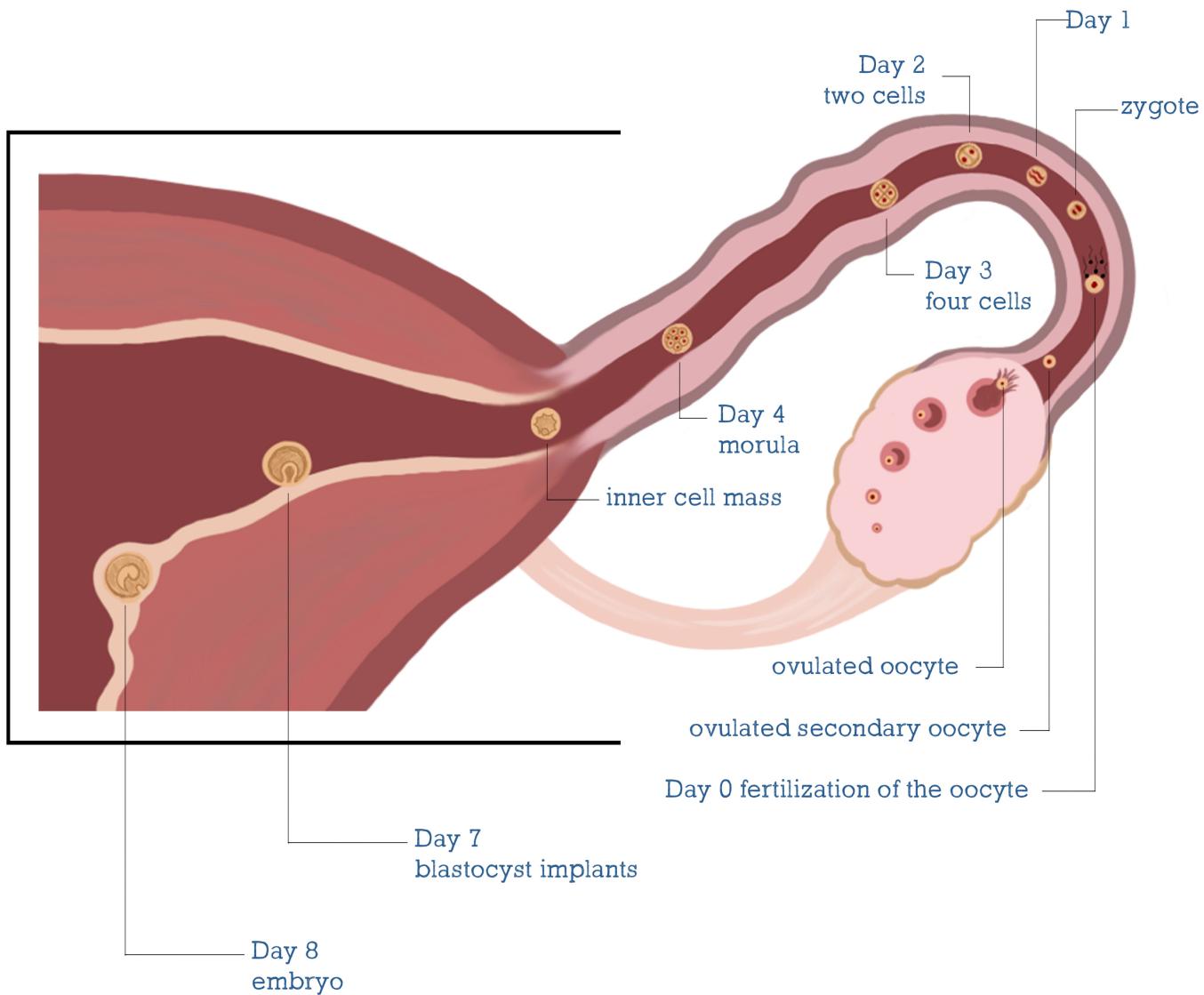
- Point out the ovary. Note that most people who have ovaries have two. During puberty, people with an ovary and a uterus will begin their menstrual cycle. Part of the menstrual cycle is ovulation, or the release of a mature egg, or oocyte, from the ovary.
- If there are sperm in the fallopian tube when an egg is released, one sperm can join with an egg. This process is known as fertilization. The sperm and the egg, now combined, and are called the zygote.
- The zygote travels down the fallopian tube and develops into a group of cells. About a week after fertilization, the group of cells (known as a blastocyst), implants into the wall of the uterus. It is at implantation that the medical field says a pregnancy officially begins, although we start counting the number of weeks pregnant a person is on the first day of their last menstrual cycle. This means that when a person becomes pregnant, they are often considered to be two weeks pregnant.
- If an egg goes unfertilized when it is released, then the uterine lining will begin to shed, creating a menstrual flow (see the “Menstrual Cycle” handout for more information).

## A Suggested Wrap-Up

Follow up with youth to check their understanding of the handout. Use the following questions to prompt further conversation:

- What information was new to you?
- Did any of this information conflict with your own knowledge of this process?
- What about reproduction would you like to learn more about?

# The Egg in the Reproduction Process



## Notes

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## Gender and Orientation Dictionaries

It can be difficult to find a good resource with definitions of gender identities and sexual orientations. This resource was developed by UN|HUSHED for our sexuality education teachers and facilitators. Please note that these dictionaries will change due to the rapidly evolving theoretical and linguistic environment that is gender and sexuality. You can visit [unhush.us/dictionaries](http://unhush.us/dictionaries) to view our up-to-date online versions.

This handout may be just for your personal use. If so, that is a great way to explore. You can also look to the “Additional Resources” section for more information to deepen your own knowledge about LGBTQ+ identities.

Please be aware that the definitions included here offer only one of many potential ways these terms may be defined. Youth may come with their own definitions based on their peers, cultures, and experiences. It is important that you honor their definitions of their identities rather than trying to get them to agree with your (or our) ways of defining terms.

When a youth discloses their gender or sexuality to you, ask what it means to them, even if they identify as female, heterosexual, gay, lesbian—terms you may feel are fairly self-explanatory. Each person has a different experience and knowing their definition and experience will aid you in your work with them and with every other youth you encounter.

### Objectives

- Broaden youth’s understanding of gender and sexual orientation
- Explore other terms that youth might use to identify themselves

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

These dictionaries can be useful to review with any youth with questions, and may be particularly useful with youth who are questioning their gender or sexuality. Providing one or both of these dictionaries for youth to explore with you and on their own can support their understanding of the many ways in which people understand, think, and talk about gender and sexual orientation. It is important to let the youth know that identity questioning and exploration is completely typical and natural and that it isn’t something that needs to be rushed.

You may also use these handouts to support youth who are trying to understand either the cultural shifts around gender and sexuality, or who have friends or relatives who have come out as LGBTQ+. Having a stronger grasp of how language is used helps many people feel more comfortable talking about gender identity and sexual orientation.

Make sure youth know that these dictionaries offer just one of the possible definitions for each term and that each person experiences their identity differently. Use the dictionaries as starting points rather than as a closed set of information.

## **Group Conversations**

Use the dictionary to choose five to seven terms that you would like to talk about with the group. Write the term and its definition on separate pieces of paper. Mix up the pairs before starting the exercise. Then have group members work together to match the terms with the appropriate definitions. Have youth share their process completing the activity. Ask group members if there are any words that stand out to them or words that they have never heard of. Explore other terms that group members have heard to express gender and sexual orientation.

## **A Suggested Wrap-Up**

Encourage youths to deepen their understanding of gender and sexuality by exploring first-person accounts such as biographies and YouTube videos. Depending on the age and maturity of the youth, you may need to prescreen the examples. Good places to start include [www.imfromdriftwood.com](http://www.imfromdriftwood.com) and [www.itgetsbetter.org](http://www.itgetsbetter.org).

## Gender Dictionary

These are words that are useful for professionals to know and be able to use fluently in discussions about gender. Some of this language may be unfamiliar to you, particularly because it evolves quickly, and some terms will be familiar, but you may not have had a specific definition to use if a youth were to ask what exactly it meant. Some of these terms are not appropriate to use, and the details of why are explained.

**Advocate**—A person who is cisgender and works and campaigns for the rights of trans, gender nonconforming, and genderqueer people and others who identify as a gender minority.

**Agender**—A person who identifies as not having a gender; or, being without gender.

**Ally**—A person who is cisgender and who works and campaigns in alliance (note the connection to the word *ally*) with people who are in the gender minority.

**Androgynous**—A balance of the feminine and the masculine that includes aspects of both.

**Bigender**—A person who identifies as having two genders.

**Biological sex**—A complex group of physical factors that are assigned to male, female, and intersex. The preferred term for this is “sex assigned at birth” because many people consider “biological sex” to be an offensive term at this point.

**Bottom surgery**—A medical procedure that changes a person’s genitals to bring them into alignment with their gender identity. Some transgender people choose to have bottom surgery, some choose not to, but many do not have access to the surgery whether they would choose to have it or not. It is never polite to ask about a person’s genitals, regardless of their gender identity.

**Butch**—A masculine-expressing person; usually refers to a lesbian whose gender roles are typically categorized as masculine.

**Cisgender**—A person whose sex assigned at birth (typically “female” or “male”) is in alignment with their gender identity.

**Cissexism**—Treating cisgender people as though they have more rights and moral authority compared to people who are gender minorities.

**Cis normative**—The assumption that cisgender people are normal and those who are gender minorities are not.

**Coming out**—Commonly understood as the first time that someone discloses their gender identity or sexual orientation, coming out is actually something that gender and sexual minorities do throughout their lifetimes.

**Correct gender pronoun (CGP)**—The pronouns (she/her/hers, he/him/his, ze/zir/zirs, they/them/theirs, etc.) that a person feels most comfortable being referred to as. Using a person's CGP is a critical part of being respectful. It may also be referred to as preferred gender pronoun (PGP).

**Cross-dresser**—A person who wears clothing that is typically assumed to belong to a different gender. Sometimes called a transvestite, although this term is not used frequently anymore and some may consider it offensive.

**Dead name**—The way some transgender people refer to the name they were given at birth. Deadnaming refers to calling a trans, nonbinary, gender fluid, or other non-cis person by the name they were given at birth rather than their chosen name.

**Desister**—A person who identified as transgender as a child but did not continue to identify as trans into adulthood.

**Drag king**—A person who dresses as and adopts the character of a man to project a kind of exaggerated masculinity, usually for entertainment purposes.

**Drag queen**—A person who dresses as and adopts the character of a woman to project a kind of exaggerated femininity, usually for entertainment purposes.

**Estrogen**—A steroid hormone that is produced by the ovaries and, in lesser amounts, by the adrenal cortex, placenta, and testes. Some transgender people choose to take this hormone so that their bodies will be more feminine.

**Femme**—A feminine-expressing person; usually refers to a lesbian or gay man whose gender roles are typically categorized as feminine.

**Gender**—A social construct that is often assumed to be aligned with aspects of biological sex, but that is far broader than biological sex. Different cultures have understood gender in dramatically different ways, with some incorporating an understanding of three or more genders.

**Gender binary**—A categorization of gender as being either male or female rather than as a spectrum. This is a harmful understanding of gender for all people because it categorizes them in ways that they might not feel comfortable with.

**Gender confirmation surgery**—A group of medical procedures that changes a person's body to bring it into alignment with their gender identity. Also called sexual reassignment surgery; most people prefer the language gender confirmation surgery.

**Gender dysphoria**—When a person's gender identity is in direct conflict with their physical body, causing mild to extreme psychological distress. Gender dysphoria is a classification of mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV)*.

**Gender expression**—The way(s) in which a person shares information about their gender through their hair, makeup, clothes, and other external aspects of their appearance that they have control over.

**Gender fluid**—A person who is able to incorporate all genders into their identity and to flow easily between them.

**Gender identity**—A person’s internal sense of how they relate or do not relate to the social constructs that their culture associates with the sex they were assigned at birth.

**Gender nonconforming**—When a person’s identity does not readily fall into their culture’s understanding of what it should be given their sex assigned at birth.

**Gender normative**—When someone or something falls into the categories that a culture considers “normal” for a specific sex assigned at birth.

**Gender norms**—The indicators that a culture assigns to specific sexes, primarily including aspects of a person that are unrelated to biology, such as hobbies, personality traits, and academic models of success.

**Genderqueer**—A gender identity that describes a person who falls outside of the stereotypical “woman” or “man” binary system. This is also an umbrella term that describes many gender identities outside of the gender binary. Genderqueer is sometimes shortened to “queer.” This term has historically been used in negative contexts but has been reclaimed by many who feel that it is more descriptive of them and their communities and experiences than LGBTQ+ or GSRD (gender, sexuality, and relationship diversity).

**Gender, Sexuality, and Relationship Diversity (GSRD)**—This describes the wide range of identities that are referred to with the term LGBTQ+, but is far more inclusive of genders and sexualities. By describing the range of identities broadly, it does not leave any identity out accidentally. It also includes relationship diversity, which refers to, for example, people who identify as polyamorous.

**Hermaphrodite**—An organism that has fully developed male and female reproductive tracts. While this term was historically used to described intersex individuals, hermaphroditism does not occur in humans and use of this term to describe people is inaccurate and usually considered offensive.

**Hormone therapy**—A part of transitioning that some transgender people choose and are able to access that shifts their balance of hormones to bring them into alignment with their gender identity.

**Intersex**—A description of anatomy sometimes assigned at birth, and sometimes discovered later in childhood, adolescence, or even in adulthood, that indicates the presence of attributes associated with both typical males and typical females. Historically, some people used the word hermaphrodite to describe people who were intersex, but this is not an appropriate term and is considered offensive by many.

**Misgender**—Using pronouns or other words that label a person’s gender incorrectly. This is often a painful experience for people, including trans and gender nonconforming people, especially when done by someone who is aware of their gender identity.

**Name change**—When a person is transitioning, they often choose a new name for themselves. This can be an important part of the transitioning process and should be respected. Asking a transgender person for their “real” name (referring to the name they were given at birth) is offensive.

**Niblet**—Also sometimes called a nibbling, this is a gender-neutral word to refer to the children of your siblings.

**Nonbinary**—A gender identification outside of the two-gender, binary system that many cultures recognize. Some people prefer to spell the word “non-binary” and others prefer “non binary.”

**Nuncle**—Also sometimes called an auncle, this is a gender-neutral word to refer to the siblings of your parents.

**Outing**—When a person discloses another person’s gender identity (or sexual orientation) without their permission. Sometimes this is done accidentally, and sometimes it is done intentionally. It is never okay to out someone.

**Passing**—When a trans person is accepted in public to be the sex that is in alignment with their gender identity rather than their sex assigned at birth. Sometimes this is a sought-after feature of transitioning, sometimes it is not.

**Persistor**—A person who identified as transgender in childhood through adulthood.

**Primary sexual characteristics**—Parts of the body directly related to reproduction.

**Queer**—An umbrella term that describes many gender identities outside of cisgender. This term has historically been used in negative contexts but has been reclaimed by many who feel that it is more descriptive of them and their communities and experiences than the term LGBTQ+.

**Questioning**—The experience of considering one’s own gender identity as potentially different from the one associated with one’s sex assigned at birth.

**Secondary sexual characteristics**—Nonreproductive-related biological differences that are connected to sex and gender.

**Sex assigned at birth**—The female or male markers that are bestowed on a baby at the time of birth. Sex assigned at birth is usually determined based on an infant’s external genitalia without taking into consideration additional aspects of the infant’s biology or eventual gender identity.

**T**—Short for testosterone, which some transgender people choose to take so that their bodies will be more masculine..

**Third gender**—A gender identity that is neither woman nor man. In cultures with more than two culturally accepted gender identities, this term would describe those identities.

**Top surgery**—A medical procedure that changes a person’s chest to bring it into alignment with their

gender identity. Top surgery can be expensive. Some transgender people choose to have top surgery, some choose not to, but many do not have access to the surgery whether they would choose to have it or not. It is never polite to ask about a person's surgical history, regardless of their gender identity.

**Transgender**—A person whose gender identity does not match the culturally assumed gender identity associated with their sex assigned at birth. Sometimes called transsexual, although this term is not in common use and some may find it offensive.

**Transitioning**—A series of steps that transgender people may or may not choose to take toward shaping their physical bodies to be more in alignment with the cultural expectation associated with their gender identity. Hormone therapy and surgery are examples of steps that some people have access to during transitioning. Some people may choose to transition without incorporating either surgery or hormones into their biology. Rather, they shift their gender expression so that it is in alignment with their gender identity.

**Two-spirit**—A third-gender marker that is used in some Native American communities to describe a range of experiences outside of cisgender and heterosexual. It is not appropriate for people outside of these communities to use this term.

## Orientation Dictionary

These are words that are useful for professionals to know and be able to use fluently in discussions about sexual orientation. Some of this language may be unfamiliar to you, particularly because it evolves quickly, and some terms will be familiar, but you may not have had a specific definition to use if a youth were to ask what exactly it meant. Some of these terms are not appropriate to use, and the details of why are explained. Some have meanings that are very close to each other and it is not always immediately clear what the differences are. Nevertheless, it is critical to honor the language that people choose for themselves rather than assuming a term with a similar definition will work just as well.

**+**—An indicator that sometimes comes after the initialism “LGBTQ” to indicate additional sexual and gender identities not explicitly included in the letters LGBTQ.

**Advocate**—A person who is heterosexual and works and campaigns for the rights of people who identify as LGBTQ+.

**Ally**—A person who works and campaigns in alliance (note the connection to the word ally) with people who identify as LGBTQ+.

**Androsexual**—A person who is romantically and/or sexually attracted to men, masculinity, and/or males.

**Aromantic**—A person who does not experience romantic attraction.

**Asexual**—A person who does not experience sexual attraction.

**Bicurious**—A person who is interested in bisexual romantic or sexual attraction. This term is most commonly used by people who have historically identified as heterosexual and are exploring same-sex romantic or sexual attraction.

**Biphobia**—A feeling or reaction to bisexuality that delegitimizes bisexuality as a sexual orientation or assumes that bisexual people are promiscuous. These reactions may come from both straight and gay communities and often leave bisexual-identified people feeling like they are rejected by everyone. Some bisexual people choose not to disclose their sexual identity because of biphobia.

**Biromantic**—A person who experiences romantic attraction to a range of gender identities rather than only one. Some people use the term to mean romantic attraction to only two genders (women and men) rather than a range.

**Bisexual**—A person who experiences sexual attraction to a range of gender identities rather than only one. Some people use the term to mean sexual attraction to only two genders (women and men) rather than a range.

**Bottom**—A word with two potential meanings: 1) a person who is penetrated during sex or 2) the person with less power in a relationship with consensual psychological or sexual power dynamics.

**Coming out**—Commonly understood as the first time that someone discloses their sexual orientation (or gender identity), coming out is actually something that sexual minorities do throughout their lifetimes. For example, for some LGBTQ+-identified people, sharing details of their social lives with new coworkers often discloses their sexual orientation.

**Conversion therapy**—An extensively discredited therapeutic attempt to alter a person’s sexual orientation so that they experience romantic and sexual attraction to the “opposite sex” in a gender-binary framework. Conversion therapy techniques range from ineffective to harmful to abusive.

**Down low**—A phrase to describe a person who is having same-sex sexual encounters and lying about that in their heterosexual relationship. This phrase is often used to discuss sexual contact between Black men but is not considered respectful. “MSM” (men who have sex with men) is the preferred language.

**Dyke**—Can be an offensive term for a woman who is (or is assumed to be) romantically and/or sexually attracted to women. It is sometimes used by lesbians with more masculine gender expressions to describe themselves.

**Emotional attraction**—A feeling of connection with another person that makes them want to be physically close together, to share intimate details of their thoughts and feelings, and to learn more about the other person.

**Fag**—Can be an offensive term for a man who is (or is assumed to be) romantically and/or sexually attracted to men. It is sometimes used affectionately among gay men.

**Fluid**—A person whose sexual and romantic attractions shift and evolve over time, or a person whose romantic and sexual attractions include a range of identities.

**Gay**—This word initially began as a secret, in-group way to ask whether someone primarily experienced same-sex romantic and sexual attraction. Over time it became an umbrella term for anyone who experienced primarily same-sex attraction. It has more recently evolved to refer to a man who primarily experiences romantic and sexual attraction to other men, although many lesbians still identify as gay.

**Grey-romantic**—A person who develops romantic attraction only after a close emotional bond has been formed; this term refers to the space between aromantic and romantic. (Sometimes spelled “gray-romantic,” sometimes also called demiromantic.)

**Grey-sexual**—A person who develops sexual attraction only after a close emotional bond has been formed; this term refers to the space between asexual and sexual. (Sometimes spelled “gray-sexual,” sometimes also called demisexual.)

**Gynesexual**—A person who is romantically and/or sexually attracted to women, femininity, and/or females.

**Heteronormative**—A culture that supports heterosexism.

**Heterosexism**—The assumption that a person is heterosexual until they have disclosed otherwise. Heterosexism is harmful for people who are not heterosexual because it requires them to come out and challenge new people's assumptions about them.

**Homophobia**—A feeling or reaction to same-sex attraction that delegitimizes any sexual orientation other than heterosexuality.

**Homosexual**—A term for a gay person that was initially intended as a descriptor but has come to be associated with negative emotional resonance for many people, and so the words gay and lesbian or the initialism LGBTQ+ is preferred.

**Lesbian**—A woman who primarily experiences romantic and sexual attraction to other women.

**Lipstick lesbian**—A lesbian who expresses herself in stereotypically feminine ways. Some people find this label offensive while others embrace it.

**Love**—A deep feeling of connection for another person. Love can be sexual, romantic, platonic, intellectual, and many other things. Our culture most commonly recognizes love when it is sexual, romantic, or familial.

**Men who have sex with men (MSM)**—Men who engage in sexual activities with other men but who do not identify as gay or bisexual. This umbrella term for men who are gay, bi, pan, etc., is often used in research and by health professionals.

**Outing**—When a person discloses another person's sexual orientation (or gender identity) without their permission. Sometimes this is done accidentally and sometimes it is done intentionally. It is never okay to out someone.

**Pansexual**—A person who is romantically and/or sexually attracted to people across a wide range of gender identities, expressions, and biologies.

**Polyamorous**—A person who falls in love with more than one person at a time. It often includes the desire to be in open, honest, and committed romantic relationships with more than one person at a time, with the knowledge and encouragement of all involved parties.

**Polysexual**—A person who is sexual with more than one person at a time. It often includes the desire to be in open, honest, and committed sexual relationships with more than one person at a time, with the knowledge and encouragement of all involved parties.

**Queer**—An umbrella term that describes many sexual identities outside of heterosexuality. This term has historically been used in negative contexts but has been reclaimed by many who feel that it is more descriptive of them and their communities and experiences than “LGBTQ.”

**Questioning**—The experience of considering one's own sexual orientation as potentially different from heterosexuality. This is an increasingly common experience among all young people, including those who end up identifying as exclusively or primarily straight.

**Romantic attraction**—Desiring a certain type of relationship with another person that involves emotional closeness and caring for each other in an intimate, fulfilling, and supportive way. Many people consider romantic attraction to be the same as sexual attraction, although others experience the two independently.

**Same-gender loving**—A term primarily describing Black men who are sexually and/or romantically attracted to men but who are not culturally comfortable with the terms “gay” or “bisexual.”

**Sexual attraction**—Feelings of physical connection, desire, and arousal. Most people have patterns of sexual attraction that may stay consistent or may evolve over time. People are not in control of who they are sexually attracted to.

**Sexual behavior**—The ways in which a person engages physically with themselves and/or others that engages the genitals and/or involves pleasure and orgasm. People are in control of their sexual behaviors. Engaging in sexual behavior that goes against a person’s attractions or identity may be psychologically and emotionally harmful.

**Sexual identity**—The way(s) in which a person thinks of themselves and their patterns of sexual attraction and behavior. This is not the same thing as sexual orientation because sexual identity is a private consideration rather than a public declaration. It is often healthy for people to be out of the closet regarding their sexual identity, but it is not always possible because of a wide range of circumstances, including family dynamics, cultural considerations, and personal responsibilities.

**Sexual orientation**—The public composite of three private aspects of sexuality (attraction, behavior, and identity).

**Sexual preference**—The decision about who a person is romantically or sexually attracted to. This terminology diminishes the reality that sexual orientation is not a choice, but something that is innate and cannot be consciously changed.

**Skoliosexual**—A person who is romantically and/or sexually attracted to people who are gender nonbinary or gender nonconforming. The origin of this word (skolio = crooked) is problematic and the use of the term is being reconsidered by many.

**Spiritual attraction**—A connection with another person that is related to and encompassing of religious beliefs and practices.

**Straight**—A person who primarily experiences romantic and sexual attraction to people of a different gender than themselves, sometimes described as heterosexual.

**Top**—A word with two potential meanings: 1) a person who does the penetrating during sex or 2) the person with more power in a relationship with consensual psychological or sexual power dynamics.

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## HIV Prevention Beyond Condoms

There are many misconceptions about HIV. Use this handout to help youth unlearn fallacies about HIV regardless of their HIV diagnosis. Keep youth informed about HIV transmission and prevention methods available, so they can make informed decisions about their sexual health. This form can be paired with the Medical Visit Checklist, which allows youth to record questions they would like to ask their medical provider.

### Objectives

- Deconstruct stigma surrounding HIV
- Learn about the risk factors for HIV transmission
- Become informed about PrEP medications and ART

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Initiate the activity by gently exploring with youth any preconceived notions they might have about HIV. When ready, ask youth what they know about HIV, and explain to youth what HIV is if they do not already know. Then go over the handout together. If they are familiar with HIV, then ask youth if they know of any factors that would put a person at high risk for HIV infection. Afterward, you can share the handout with youth and look at the “Am I at high risk?” section together to see how the youth’s answers compared.

Check in with youth to see if any of the factors surprised them. It is important to stay mindful that youth might have complex feelings toward HIV infection, especially if they meet high-risk criteria, already have a diagnosis, or have family members who have a diagnosis. Be sure to validate youth’s perspective when discussing different therapies and drugs available to them and their sexual partners. Invite youth to consider how comfortable they are talking about HIV with friends, family, romantic partners, and other people in their lives, and reflect on what factors influence that level of comfort. Discuss cultural messaging related to HIV to identify what needs to be unlearned and what youth

### Group Conversations

Hearing other people’s experiences first hand can be a great way to destigmatize HIV and strengthen a sense of community for people who have a diagnosis. Contact local agencies and community partners who might know of adults interested in volunteering and talking comfortably about their experiences with HIV to a group of youth. Coordinate a time for these adults to share their experiences with youth. Provide youth an opportunity to ask questions and share reflections before ending the session.

### **Suggested Wrap-Up**

When wrapping up, explore with youth what they learned and how that will shape their behavior moving forward. Further support youth by offering available resources for them to access. If able, encourage them to record any questions they might have on the Medical Visit Checklist handout further in the handbook to help prioritize their sexual health at their next medical visit.

# HIV Prevention beyond condoms

**STOP THE STIGMA, BE INFORMED!**

## HIV

HIV stands for Human Immunodeficiency Virus. It stops an infected person's immune system from keeping them healthy. If HIV goes untreated, it leads to AIDS. In the past, condoms have been the only way to prevent an HIV infection. But now we have more options!

### **People Living with HIV**

The medications to control HIV, which is called antiretroviral therapy (ART), are taken daily for the rest of a person's life and can reduce the virus in a person's immune system so much that a test can't find it. This is called being undetectable. When the HIV is undetectable, it is also untransmittable! This is called U=U and means the person living with HIV will not infect anyone else with HIV.

### **People Who Are HIV Negative**

There are currently two drugs used to prevent HIV infection. Taking one pill, every day is very effective at reducing the risk. There are two medications are for people who are HIV negative, at higher risk, and weigh over 35 kg (~77.5lbs):

- Truvada, approved for everyone
- Descovy, only approved for people with penises

GetYourPrEP.com and the GileadAdvancingAccess.com both offer financial assistance for PrEP.

### **Am I at high risk?**

Finding out your risk for HIV infection is a conversation to have with your medical provider.

Generally, those at higher risk for HIV infection include:

- People who have sex without condoms.
- People who have sex with people who are HIV positive and not receiving treatment.
- People who do not know the HIV status of their partners.
- People who inject drugs and share needles.
- People who have sex with gay and bi men and trans women.

**Get tested frequently. Ask about PrEP. End the Stigma.**

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## Intimate Partner Violence: Types

The Centers for Disease Control and Prevention reports that 1 in 3 women and 1 in 4 men are physically abused by a romantic and/or sexual partner during their lifetime. Even though it is a very serious issue, intimate partner violence (IPV) is often portrayed by the media as romantic rather than scary, harmful, and traumatic. This handout introduces the five types of IPV: sexual, physical, stalking, financial, and emotional and verbal. It is useful to pair this handout with others, such as “Columns and Shadows” and “Communication Styles.”

Pairing this handout with the “Columns and Shadows” model can allow you to introduce less severe forms of IPV, which are often warning signs of the forms presented in this handout. Combining these two handouts may be a gentler approach to a conversation about relational violence, and using examples from “Columns and Shadows” can allow you to discuss how youth connect with the five types of IPV.

Professionals pressured by time constraints, such as direct care staff or case managers, could introduce “Columns and Shadows” first and then at a later time introduce this handout. Pay particular attention to types of IPV that the media portrays as romantic, like stalking (portrayed to be a sign of “true love”) and financial control (shown to be a sign of “taking good care of” a partner).

Be sure to gather resources for people experiencing IPV to provide to youth after talking with them.

### Objectives

- Increase knowledge about intimate partner violence
- Be able to recognize signs of an abusive partner
- Provide an opportunity for youth to seek help if needed

### Individual Conversations

A trauma-informed lens is critical to introducing this information in a way that is effective and supportive rather than retraumatizing or degrading toward youths’ parents who have experienced intimate partner violence.

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Use this tool for prevention or intervention, depending on the youth’s needs and their capacity to be trauma informed. Provide the handout to the youth and discuss each of the five types of IPV. Remember to validate their feelings and process thoughts throughout the discussion.

Some examples of IPV include:

- Unwanted massages

- Unwanted texts or calls
- Climbing through a window uninvited
- Unsolicited sexual messages such as stories, poems, and nude pictures
- Getting cornered
- Being called mean names
- Being told how “beautiful” or “sexy” you are
- Not being “allowed” to pay
- Being kissed without your permission/enthusiastic consent
- Being intimidated
- Gaslighting (making a person believe that they can’t trust themselves or their perception of reality)
- Being physically hurt

One way to explore this activity could be by using popular movies, television shows, or song lyrics that the youth likes. Allow the youth to describe the scene and process the information from there. Depending on your youth’s experiences, this activity could evoke unpleasant feelings from the past. Therefore, allow the youth to lead when processing their reactions and past experiences. Do not push the youth to share. Use mindfulness techniques such as deep breathing if the youth becomes dysregulated.

## **Group Conversations**

A trauma-informed lens is critical to introducing this information in a way that is effective and supportive rather than retraumatizing or degrading toward youths’ parents who have experienced intimate partner violence.

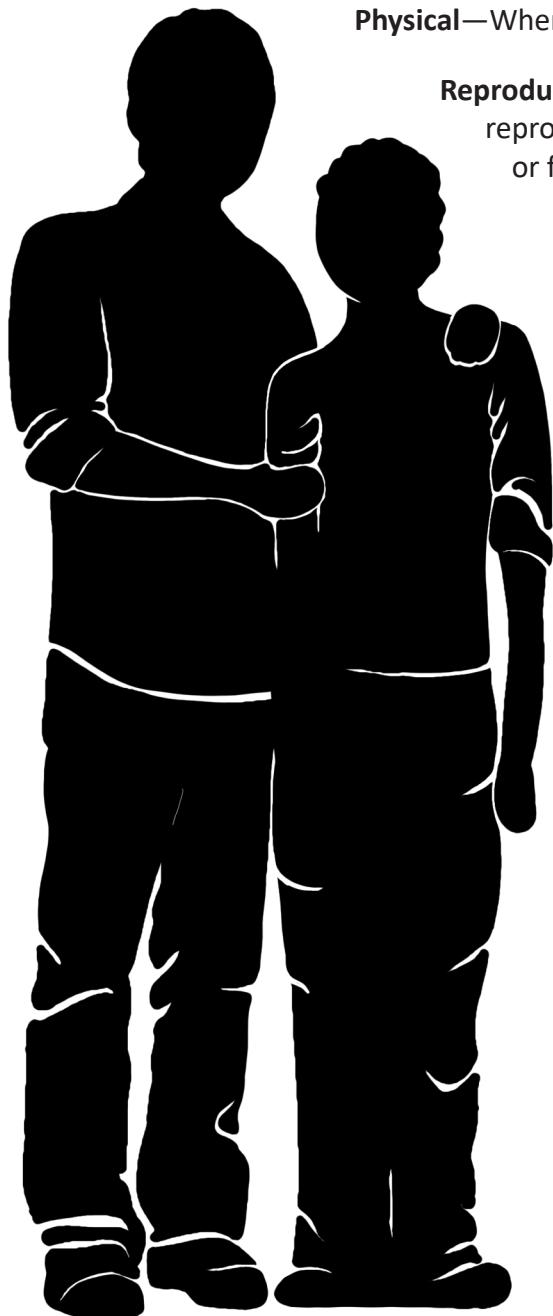
## **Suggested Wrap-Up**

Before ending the session, provide youth with resources for people experiencing intimate partner violence, including a hotline number and programs for youth with parents experiencing intimate partner violence. Ask youth how comfortable they would be reaching out for help if they thought their relationship was becoming dangerous. It is also helpful to normalize that many people possess feelings of shame when asking for help. Explore past instances when youth felt comfortable asking for help and how that compared to instances when they did not feel as comfortable.



These are also referred to as: Relationship Abuse, Intimate Partner Violence, Relationship Violence, Dating Abuse, Domestic Abuse, and Domestic Violence.

**Emotional and Verbal**—When someone threatens, insults, or otherwise psychologically harms their partner or person they are on a date with.



**Physical**—When someone hurts their partner's or their date's body.

**Reproductive**—When someone controls their partner's reproduction by withholding or sabotaging contraception or forcing a pregnancy termination.

**Sexual**—When someone forces or pressures their partner or date into sexual contact that they don't want or weren't able to consent to.

**Stalking**—When someone follows another person or repeatedly contacts them against their will, or without their knowledge.

If you need help for yourself or someone you know please reach out to any of the following resources:

- Futures Without Violence  
<https://www.futureswithoutviolence.org/>
- Love Is Respect  
<https://www.loveisrespect.org/>
- Teen Dating Violence  
<https://www.teendvmonth.org/>
- The National Domestic Violence Hotline  
<https://www.thehotline.org/>

Authors: Karen Rayne, PhD, CSE; Jessica Smarr, MPH

Design: Nyk Rayne

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## Medical Visit Checklist

Going to the doctor for sexual health concerns can be an overwhelming experience. This handout is a tool for youth to use to prepare for the appointment and to process it afterward. Youth will learn what items are needed for the appointment and how to establish what they would like to talk about. Youth will also be able to take notes during the visit about their discussion with the provider and medical terms that they would like to look up later.

### Objectives

- Promote youth's sense of agency regarding sexual health
- Prepare youth for the medical visit
- Record notes during the medical visit to follow up on

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Use this handout as an opportunity to check in with a youth about their upcoming medical visit and see how they feel about it. Give them a moment to express any feelings and concerns they have regarding the medical visit. Normalize and validate their feelings and concerns. Ask the youth if they would be willing to learn about a handy tool that might boost their confidence about the medical visit. If they agree, proceed by giving them a copy of the handout.

You can start at the top of the handout and work your way down. If the youth appears to be overwhelmed or anxious, then skip straight to "What I want to talk about" and "My symptoms." This will provide them with an opportunity to cope and enter a headspace that can process what is needed. Follow up with an open conversation about self-regulation tools and ways to use them in medical appointments as needed.

Point out to the youth that they can add any other items about their sexual or general health in the blanks. You may also encourage them to put all of this more permanent (rather than visit-specific) information into their cell phone, if they have one.

Encourage youth to use the "My medical provider told me" and "Medical terms to look up later" sections during their medical visit to help them process information afterward. If they have questions after the medical visit, you can help them save the questions for their follow-up medical visit on the back of their handout or on a new copy of the handout. Alternatively, you can normalize open and accessible communication between the youth and their medical provider and encourage them to call their medical provider's office directly.

For some youth, it might be the first time they see a medical provider who assesses sexual health, and the experience could remind them of past trauma. Youth might wonder if appropriate protocol

was used or if a doctor or nurse crossed a line. Be sure to take this into consideration and coordinate additional support with their counselor or other trusted adult that the youth is comfortable speaking to.

## **Group Conversations**

Group facilitators will need to prepare for this activity by completing a handout with generic examples of issues that someone might see a sexual health provider for. Give each group member one completed handout with this unique and fictitious information on it and a blank handout for them to use on their own. The group facilitator will explain how the handout should be used to prepare for a medical visit. Afterward, youth will break up into pairs and role-play telling a doctor the information on the form, and then switch roles. This provides youth an opportunity to practice their communication skills and to reflect on possible questions to ask a medical provider.

## **Suggested Wrap-Up**

Follow up with youth to see if their confidence level toward their medical visit has changed. If the youth still seem uneasy, collaborate with them on ways to overcome barriers diminishing their confidence. Inform youth that you recognize that taking responsibility for one's own sexual health can be overwhelming at times and that you are available to talk if they ever have any questions or concerns.



# Medical Checklist

## An Introduction to Human Sexuality

Seeing a doctor, nurse, or other medical provider can feel scary or overwhelming.

Fill out this handout and take it with you when you see your sexual health provider to help remind you of what you wanted to talk about. The things you want to talk about are important, valid, and it is the medical provider's job to support you.

Things I need to bring with me:

Identification

Insurance card

Form of payment

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

My Medicaid Number:

My medications: name/dosage

\_\_\_\_\_

My conditions: diagnosis name(s)

\_\_\_\_\_

What I want to talk about:

\_\_\_\_\_

My symptoms:

\_\_\_\_\_

\_\_\_\_\_

My medical provider told me:

Notes from your provider

such as suggestions about

next steps.

\_\_\_\_\_

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Medical terms to look up later:

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# Menstrual Cycle

Not every person menstruates, but every person should have some knowledge about how menstruation works. Use this handout to gain a better understanding of the menstruation cycle, so you can share that knowledge with youth. This handout can be paired with the “Medical Visit Checklist” for youth who might have questions or concerns about their own menstruation cycle.

## Objectives

- Normalize menstruation
- Learn about the process of menstruation
- Introduce menstruation products

## Individual Conversations

### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Familiarize yourself with the handout and use it to guide your conversation with youth. Ask youth what they already know about menstruation and what questions they might have about the topic. When using the handout with youth, encourage them to annotate it, for instance drawing arrows or brackets along the ovulation dial. Remember to not get caught up in the names of the phases or other jargon. Instead, check for understanding about the purpose for each stage and any other questions youth might have. Afterward, talk to youth about different menstruation products that can be used during menses. Explore how menstrual flow, personal preference, and planned activities could influence youth’s choice of menstruation products. If you are unable to confidently answer these questions, then encourage youth to record them on the Medical Visit Checklist handout and ask their medical provider at their next visit.

## Group Conversations

Society does not provide a lot of space to talk about direct and indirect experiences with menstruation. In a group setting, invite youth to share their experiences, knowledge, and questions about menstruation. Maintain a nonjudgmental presence to normalize conversations about menstruation through modeling. A good starting prompt is “Something I have always wondered about menstruation is...”, or “What has the media taught you about menstruation?”

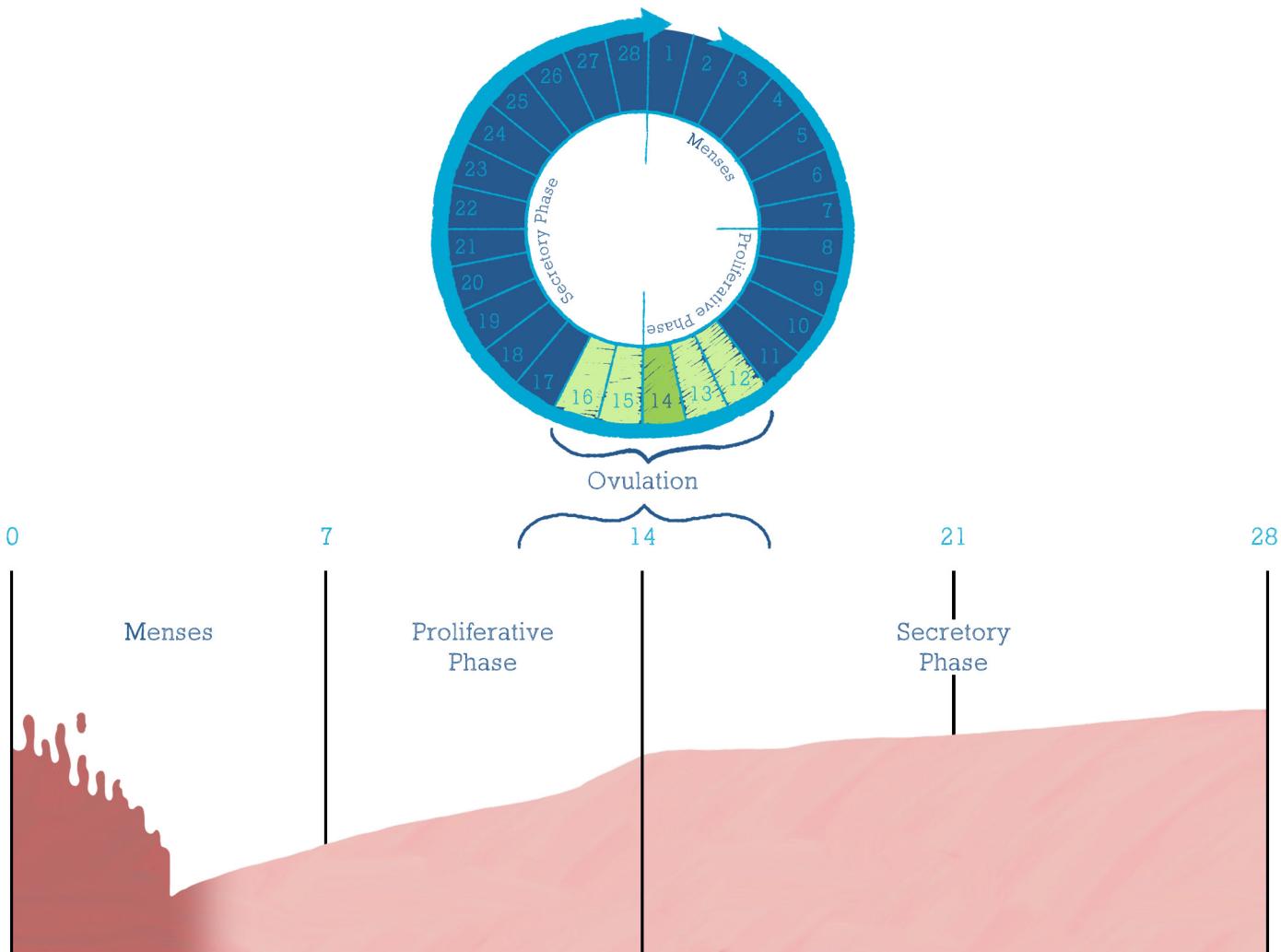
## Core Information

- During puberty, people with an ovary and a uterus will begin their menstrual cycle.
- During the secretory phase, the uterine lining will produce hormones that will support either fertilization or menses. This phase of the menstrual cycle includes ovulation, or the release of a mature egg, or oocyte, from the ovary.
- When an egg is released, hormones such as progesterone and estrogen are released to prepare for early pregnancy. If fertilization does not occur, then these hormone levels will drop, prompting the uterine lining to break down, which creates a menstrual flow also known as a menses.
- It is typical to experience premenstrual syndrome symptoms such as mood swings, headaches, acne, bloating, and cramping due to hormonal fluctuations.
- During the proliferative phase, the uterine lining begins to build back up to prepare itself for the next ovulation period.
- In mid-adulthood people enter perimenopause when their ovaries experience a decrease in estrogen production, making periods more irregular. People can still become pregnant when in perimenopause, though it can be more difficult.
- People have transitioned into menopause when they have not experienced a period in more than 12 months. Menopause usually occurs after 45 years of age when progesterone and estrogen production has ceased.

## Suggested Wrap-Up

Menstruation products are not always accessible to youth in foster care. Consider setting up a create-your-own-period-kit table to better support youth sexual health. This table can include various menstruation products such as tampons, pads, liners, and menstrual cups. Don't forget to provide discreet bags or pouches for youth to store their products in. Be sure each bag has information inside about menstruation and local resources available. It is important to offer a create-your-own-period-kit to every person regardless of whether they menstruate. Everyone should familiarize themselves with menstrual products to normalize menstruation and possibly unlearn implicit bias regarding the matter.

# Menstrual Cycle



## Notes

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## Period Tracker

Teaching youth how to track their menstrual flow and premenstrual syndrome (PMS) symptoms can provide them with a sense of empowerment over their reproductive health. Youth will be able to predict their next period and have insight on why they might be experiencing shifts of physical and emotional well-being associated with PMS. Additionally, this tool can help youth advocate for their reproductive health by collaborating with doctors to help treat irregular periods or intense PMS symptoms. While it might be useful to look at this handout as the beginning of a discussion, if youth have access to smartphones, you may also recommend that they consider one of the many available flow tracker apps.

### Objectives

- Provide youth with a sense of control by teaching them how to predict their period and PMS symptoms
- Help youth identify whether or not it would be useful to consult with a medical professional about their menstrual cycle
- Help counselors rule out premenstrual dysphoric disorder when working with youth

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Introduce this tool to youth who will or are experiencing a menstrual cycle. Ask youth if they already track their period or premenstrual (PMS) symptoms and collaborate with them to consider the benefits of doing so. Encourage youth to assign colors or symbols to the Flow Key on the bottom of the Period Tracker Chart to allow them to track more effectively. Inform youth that it is typical for a menstrual flow to fluctuate from month to month. If time permits, have youth record data for past months if they remember.

Point out the Premenstrual Syndrome Symptom Tracker next. Take time to look over both the physical and emotional/behavioral symptoms listed. Speculate why emotional and behavioral symptoms are grouped together and how they might be connected. Explore with youth how PMS symptoms can impact one's mental health, relationships with others, and ability to perform well at school or work. Encourage youth to add any other PMS symptoms to the chart that are applicable to them. Ask youth if they would change anything about the tracker to make it more unique to their needs. Connect youth to appropriate personnel if they share personal concerns about irregular menstrual cycles, pain during their menstrual flow, or PMS symptoms. If time permits and the youth has access to a smartphone, you can spend time with youth and explore different phone apps that track periods and PMS symptoms.

#### *Counselors*

Take this exercise further to help youth identify how PMS may be related to trauma symptoms. Additionally, counselors can teach youth how to mitigate the effects of emotional PMS through

relaxation or therapeutic techniques. Lastly, certified mental health professionals could use this tracker as a means of ruling out premenstrual dysphoric disorder amongst youth.

## Group Conversations

Use the worksheet as a psychoeducational tool in a group setting. Explain how to use the worksheet and clarify any questions youth might have. Ask group members if any of them have tracked their menstrual cycle or PMS symptoms before. If yes, follow up by asking how it was helpful.

The Premenstrual Syndrome Symptom Tracker provides an opportunity for youth to think critically about their PMS symptoms. Ask youth how someone might be able to tell when they are about to start their period. Explore how PMS symptoms affect them and their relationships. Normalize group members' experiences by pointing out similar themes said by other members. Encourage group members to help brainstorm more effective ways to manage PMS symptoms. Invite group members to test out new ways to alleviate PMS symptoms and report back to the group.

## Core Information

- The menstrual cycle begins on the first day of the period and ends when the next period begins. On average, a menstrual cycle ranges between 24 to 38 days with a period duration of five to seven days.
- It is typical for people's menstrual cycle to be irregular when first getting a period. Youth should seek guidance from a medical healthcare professional if irregular menstruation persists after the first three years of experiencing an initial period. Other factors that can affect menstrual flow irregularities are stress, low weight, pregnancy, birth control, and eating habits.

## A Suggested Wrap-Up

After a youth tracks their menstrual cycle a few times, they will be able to see patterns in their menstruation and PMS symptoms. Ask youth if they would like to set up a health appointment to discuss their menstruation or PMS symptoms. Encourage youth to bring the information they tracked and to identify patterns they have observed to share with a doctor or nurse. Help youth identify any questions or concerns to ask the doctor during the appointment.

## Period Tracker

| FLOW TRACKER |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|--------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|              | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
| Jan          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Feb          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Mar          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Apr          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| May          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Jun          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| July         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Aug          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Sep          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Oct          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Nov          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Dec          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**KEY**

**S** spotting   **L** light   **M** medium   **H** heavy

| PMS SYMPTOM TRACKER |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
|---------------------|-------|------|-----------|-------------------------------|--------|----------------|---------|----------|------------|-------|--------|------|-------|------------------------------------------------|
| Physical Symptoms   |       |      |           | Emotional/Behavioral Symptoms |        |                |         | Notes    |            |       |        |      |       |                                                |
|                     | chest | head | intestine | skin                          | uterus | overall energy | anxiety | appetite | depression | focus | libido | mood | sleep | any additional info for you/your care provider |
| Jan                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Feb                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Mar                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Apr                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| May                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Jun                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| July                |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Aug                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Sep                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Oct                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Nov                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |
| Dec                 |       |      |           |                               |        |                |         |          |            |       |        |      |       |                                                |

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## Relationship Behaviors

Youth who have experienced family or intimate partner violence can have a different perspective on what is a healthy or unhealthy relationship behavior. This handout gives youth an opportunity to decide for themselves what constitutes a healthy, unhealthy, or borderline behavior in a relationship. This exercise can be completed by adolescents who are interested in understanding family violence, who are dating, or who are participating in sexual relationships.

### Objectives

- Encourage youth to think critically about relational behaviors
- Reflect on what makes a behavior healthy, unhealthy, or borderline
- Use as an evaluation tool when completing other handouts about relationships or intimate partner violence

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Use these materials to complete a relationship behaviors exercise with youth. Copy the first handout and cut out the listed behaviors into separate pieces or write the behaviors on Post-it notes. Ask youth to use the Venn diagram to sort the behaviors into the categories of healthy, unhealthy, or mixed. Inform youth that the mixed area is for behaviors that feel more ambiguous or that the youth is unsure of. Whether a behavior falls into this middle category might depend on the specifics of the situation, such as whether other people were around or the frequency of the behavior. It is important to be silent and not interrupt the youth as they complete the exercise. Ask youth to share their experience completing the handout. For instance, ask them “What factors played a role in determining if a behavior was healthy or unhealthy?” or “Were there any behaviors that you had difficulty sorting?”

Explore the youth’s reasoning for placing behaviors in the center of the Venn diagram, in the “mixed” category. Ask youth what it would take for one of the behaviors in the center to be categorized as healthy or unhealthy. When youth come up with healthier alternatives for behaviors they have categorized as unhealthy, encourage them to write those alternatives down on the healthy side of the Venn diagram. Reflect on situational factors that would help youth categorize the behavior as healthy or unhealthy, such as how the youth feels as a consequence of the behavior. Before ending the exercise, ask youth if they would recategorize any of the behaviors that they sorted. If they say yes, encourage them to shift the behaviors around.

If time is available, explore ways youth can navigate unhealthy behaviors in a relationship, such as setting a boundary or seeking help from someone they trust. Alternatively, you can ask them if they participate in any of the healthy or unhealthy behaviors. Help them think critically about the impact of both their healthy and unhealthy behaviors on relationships. Collaborate with them and ask their

opinion about strategies they can use to build capacity for more healthy relational behaviors. Lastly, discuss the impact of these behaviors on one's sexuality and sexual health such as contraception use, family planning, and feelings of worth.

It is important to remember that youth could be triggered by this exercise. Let youth know that they can stop participating in this exercise or discussion whenever they want. Be sure to connect youth to counseling services if they become dysregulated. Alternatively, you can ask them what they would do to make themselves feel better. Introduce them to new coping strategies if they cannot readily think of one to use.

## Group Conversations

Have youth stand in a large circle with enough space for youth to step inward and not feel crowded. Inform group members that you will be giving examples of scenarios about two people in a relationship. Group leaders can use the content from this handout to create scenarios such as "Sam gets **intensely jealous** when their partner hangs out with others" or "When Sam gets angry, they **yell insults** at their partner and **threaten to break up**." For each scenario, group members will decide if they would be concerned enough about a friend experiencing this kind of behavior to think they should seek help or leave the relationship. If so, then group members will step inside the circle.

You can ask youth standing in the outer circle to internally, without talking about it, rate how healthy the described behavior is on a scale of one to five.

Next, ask group members who stepped inward to discuss some of the following questions:

- What was concerning about this scenario?
- Did you think the person should seek help or leave? Why?
- What does seeking help look like?
- Who could help?
- What happened for the person to decide to leave the relationship?
- Who might support a person leaving this kind of relationship?
- How could a person leave safely?

Afterward, ask the outer circle to decide on a ranking again. They can share their ranking and the reason they choose it if they want to, but they are not required to. This activity can be as long or short as you like depending on your group's interest. Some group members might want to come up with their own scenarios for the group.

## Suggested Wrap-Up

This exercise can be helpful to complete before introducing the other handouts related to intimate partner violence. Afterward, when presenting the other handouts, you can return to this one to see if youth recategorize certain behaviors. If you plan on doing this, write the behaviors on Post-it notes instead of on pieces of paper. This will allow youth to physically move the behaviors from one side of the Venn diagram to the center or other side.

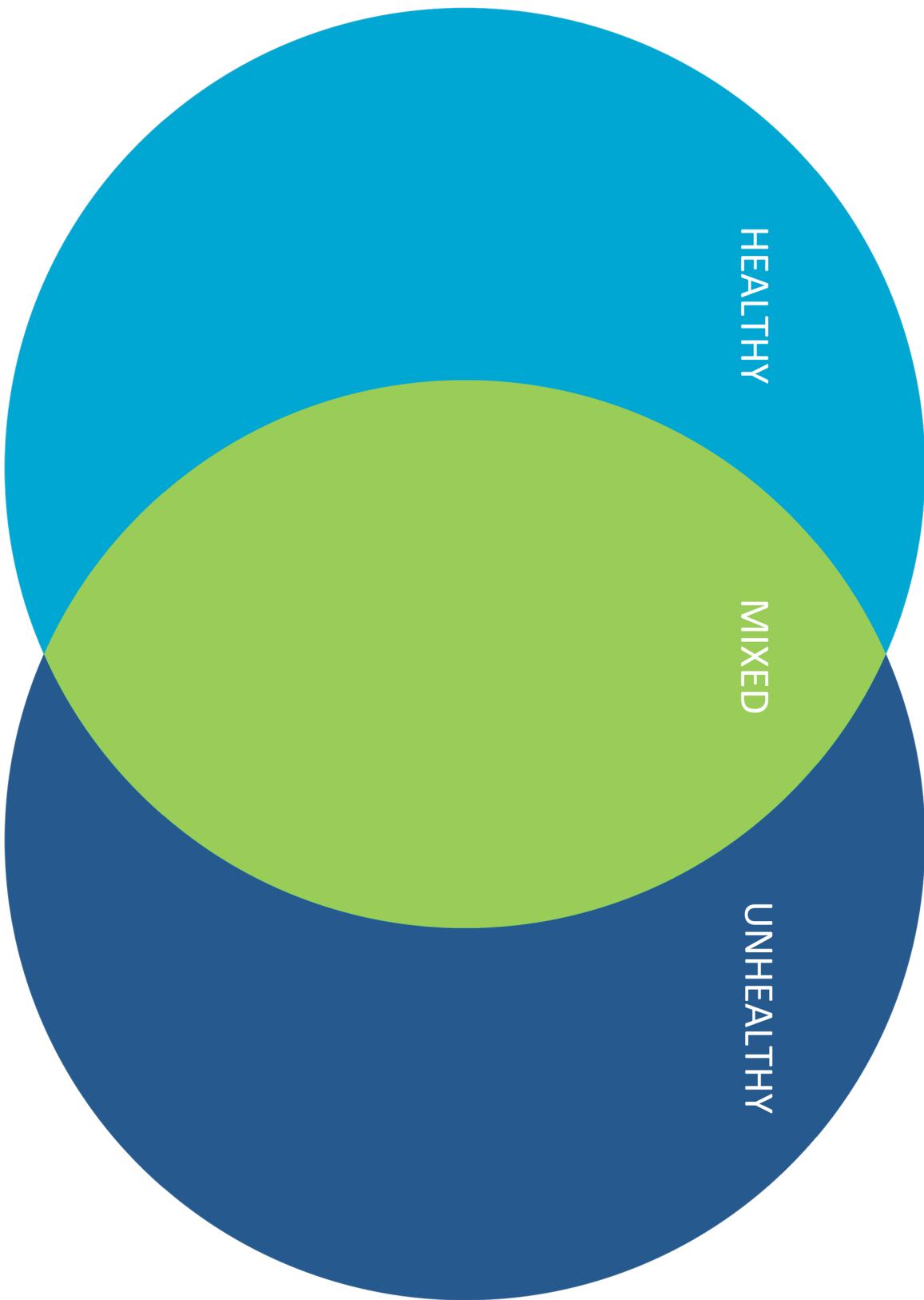
Additional follow-up questions:

- How has your perspective on relationships changed after all of these exercises?
- What happens if two people have a different idea of what a healthy or unhealthy behavior looks like? How could that influence their relationship?

If youth have completed the “Sexualitree” handout, you can integrate those concepts into the discussion as well. This can include examining how a youth’s cultural, relational, and intimacy levels influence their perception of healthy and unhealthy relationship behaviors.

# Relationship Behaviours

## An Introduction to Human Sexuality



|                                                       |                                                |                                              |
|-------------------------------------------------------|------------------------------------------------|----------------------------------------------|
| Accepts responsibility for self                       | Gets mad when partner doesn't respond to texts | Respects partner's boundaries                |
| Accuses partner of cheating                           | Gives partner gifts                            | Respects partner's decision to break up      |
| Admits being wrong                                    | Honors partner's emotional needs               | Respects partner's relationships with others |
| Admits when wrong                                     | Insults partner                                | Shames partner in public                     |
| Asks partner if it is okay before doing something     | Is honest with partner                         | Supports partner's goals                     |
| Asks partner who they were with                       | Jokes with partner                             | Takes action to make partner feel safe       |
| Becomes jealous                                       | Keeps partner away from friends and family     | Takes lead in relationship                   |
| Calls or texts partner all the time                   | Learns from mistakes                           | Taking partner's money                       |
| Catfishes partner on social media                     | Listens to partner                             | Threatens to break-up                        |
| Cheats on partner                                     | Makes decisions together                       | Threatens to hurt self                       |
| Clenches fists as if to hit partner                   | Makes partner nervous                          | Throwing objects                             |
| Comments partner's appearance                         | Makes partner think they're crazy              | Uses sarcasm                                 |
| Contacts partner's friends and family for information | Partner's friends do not like them             | Values partner's opinions                    |
| Disagrees with partner                                | Physically hurts partner                       | Waits to talk to partner until they are calm |
| Doesn't like partner's friends                        | Prevents partner from using birth control      | Willing to compromise to solve conflict      |
| Freely expresses emotions                             | Prevents partner from using phone              | Yells at partner                             |

## Notes

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## Ringerangeroo and Doodle-Dasher, Too

This fun and educational activity was developed by Jessica Smarr, MPH, of UN|HUSHED, to show how different types of sexual acts were discussed throughout history. Smarr used Jonathon Green's research to develop this activity. More information on Green's research can be found at [www.thetimelinesofslang.tumblr.com](http://www.thetimelinesofslang.tumblr.com).

This handout can be used to normalize sexually explicit language so that youth feel like they are able to talk with you about sexual issues that come up over your time working with them. Sexual slang and euphemisms have (clearly) been common throughout history. This handout highlights that fact, which can provide an opening to making sure that you and the youth have a common language to discuss sexual activities.

This handout also has the possibility of opening discussions about how the meaning of words that are supposed to describe sexual activities are not always clear. Even a word that someone may assume is obvious to everyone may not be. For example, some people (especially young people) may believe that "oral sex" means kissing. Others may believe that "sex" does not include oral sex.

Whether you agree to use the often-amusing historical language included here or language that your youth brings to the conversation, discussing the meaning of these words will ensure that you are all on the same page rather than guessing or assuming what each other means. It provides an opportunity for youth to have the same kind of clarifying conversations with a partner. Mutual understanding about what words refer to what sexual activities are critical to maintaining sexual health.

Think of this handout as an educational icebreaker. Its main purpose is to be fun, informative, and normalizing. Do not be afraid to laugh with the youth as they explore the terms.

### Objectives

- Explore how societal expectations are communicated by the way we talk about sex
- Learn about healthy ways to talk about sex
- Find shared terms to talk about sexual activities

### Individual Conversations

This exercise is divided into two parts. Part 1 can be facilitated by caregivers, direct care staff, case managers, and counselors. However, only providers who have additional training, such as caregivers and counselors, should complete Part 2.

#### ***Caregivers / Case Managers / Counselors / Direct Care Staff***

##### ***Part 1***

Ask youth if they are comfortable talking about this topic with you. It is possible that youth might have experienced molestation or sexual assault in which secret terms were used to talk about sexual

activity. Be prepared to safety-plan with youth by introducing coping strategies if they experience negative emotions from the conversation. Be ready to connect youth to their counselor and additional supports if necessary.

Ask youth if they have heard of sexual activity being compared to “bases,” like in baseball. If they have heard of this, ask them what specific activities they associate with each “base.” If a youth has not heard of this, ask them to brainstorm slang, metaphors, or other words they have used or heard others use to allude to sexual activities.

Ask the youth if they have ever heard of sexual activity being compared to pizza. If they have not (or even if they have) take a minute to watch Al Vernacchio’s Ted Talk on the subject of sexuality as a pizza ([www.youtube.com/watch?v=xF-CX9mAHPo](https://www.youtube.com/watch?v=xF-CX9mAHPo)).

### ***Caregivers / Counselors***

#### **Part 2**

Provide the handout to youth and let them know that talking about sex has been taboo throughout history. In order to get around negative cultural associations that shut down the conversation, every age and every place has had slang terms about sex and sexuality. In fact, in the 1930s, “ringerangeroo” was a slang term for vagina, and “doodle-dasher” was a slang term for penis.

Read over the different historical terms for each of the four primary kinds of sexual activities listed on the handout. Check to make sure your youth fully understands what the four types of sexual activities actually entail. Ask your youth what words they and their friends use, and write those on the handout. Let them know that the two of you can use any terms that they feel comfortable with, as long as you both know what the words mean.

### **Group Conversations**

In a group setting, introduce the handout to group members by following the instructions in Part 2. Afterward, have group members anonymously write down slang terms about sex that they have heard on folded Post-its. Then read out each Post-it and have group members guess which of the four categories the slang term represents. Then stick the Post-it notes under that category in a visible place.

Throughout the process, discuss how slang terms can have different meanings for different people. Once all the slang terms are sorted, ask youth what stood out to them about this exercise. Alternatively, you can further the conversation and explore how some words might have negative connotations and perpetuate negative stereotypes about sex. Others have more positive meanings. Then ask youth which of the words on the Post-it notes or handout are positive versus negative.

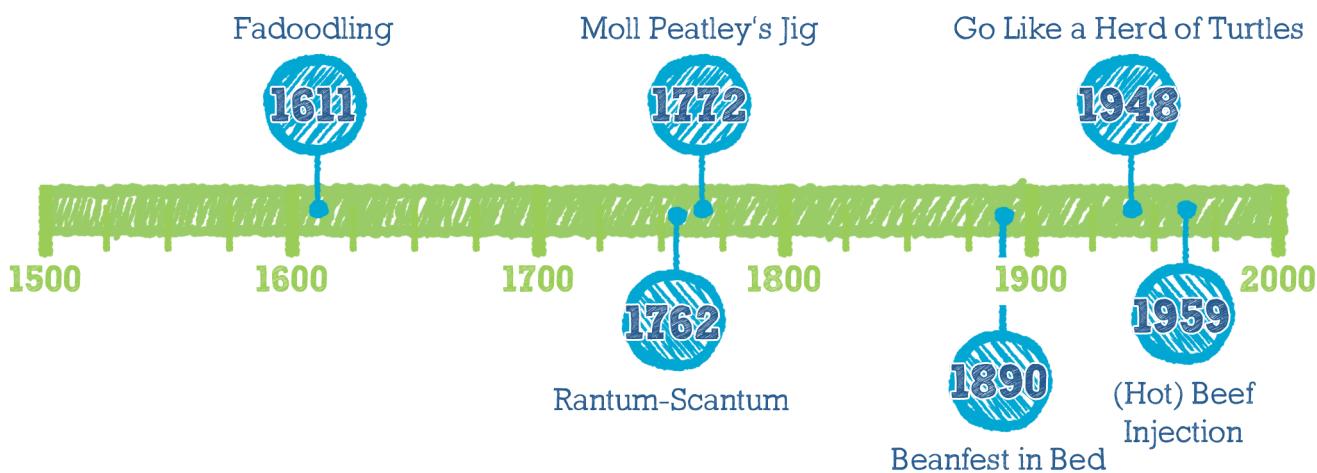
## Suggested Wrap-Up

Follow up with youth by asking:

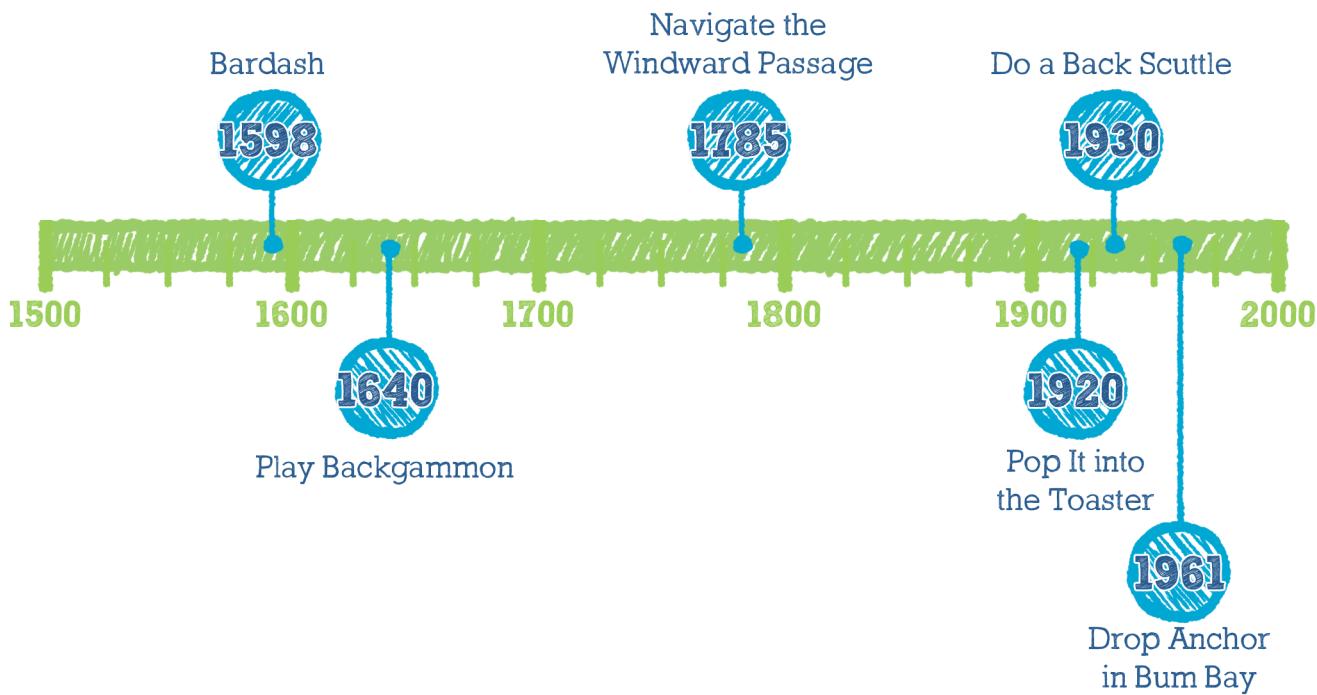
- How has your perception changed when talking about sex?
- What type of underlying meaning do you want the slang you use to portray? How come?

## Ringerangereroo and Doodle-Dasher, Too

### Vaginal Intercourse



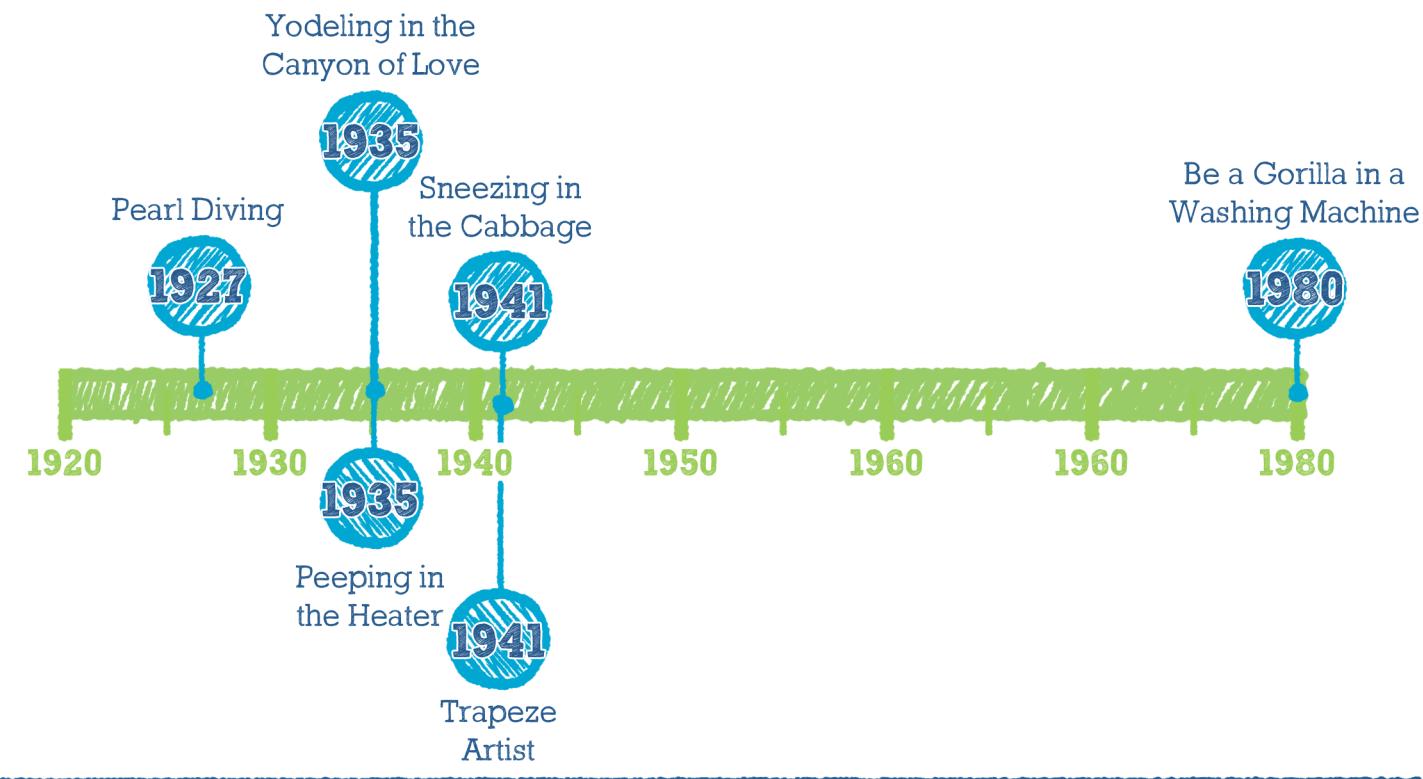
### Anal Intercourse



## Ringerangeroo and Doodle-Dasher, Too

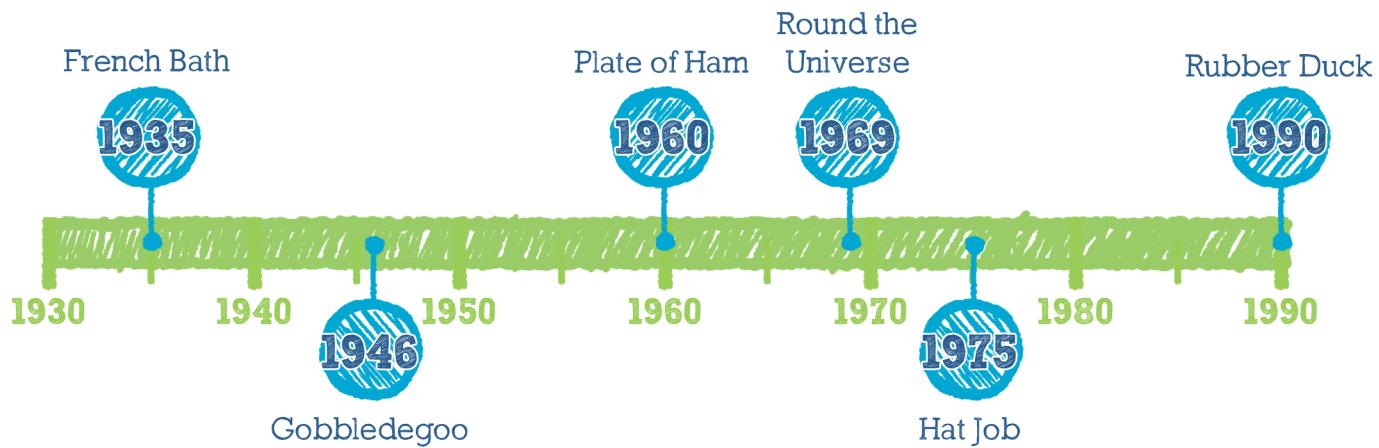
### Cunnilingus

(Oral sex involving the vulva)



### Fellatio

(Oral sex involving the penis)



## Notes

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## Safe People

In child welfare, it can sometimes seem unclear whose responsibility it is to educate youth about sexual health. Talking to youth within the child welfare system about sexual health can feel taboo for the adults in their lives, especially if laws or agency policies restrict the conversation. Additionally, transient youth can feel very isolated and disconnected from a community of caring, askable adults.

Use this tool to help youth identify up to three safe people they are comfortable talking with about sexual health. Normalize talking about sexual health while being clear about the limits of confidentiality. Youth might feel apprehensive about this conversation because they don't have any adults in their lives who feel safe or askable. Be ready to validate youths' past experiences seeking help and use this handout as a resource for youth who have difficulty identifying safe people in their lives. This handout can be broken down into multiple sessions in order to account for time limitations or youth comfort with the topic.

### Objectives

- Explore a variety of topics that relate to sexual health
- Help youth consider sexual health topics they would like to learn more about
- Help youth identify three people they feel safe talking about their sexual health with
- Encourage youth to reflect on the likelihood of talking about sexual health to one of the identified people

### Individual Conversations

#### *Caregivers / Case Managers / Direct Care Staff*

Use this handout as a means to build confidence with youth when speaking with them about sexual health and about feeling safe during those conversations.

Before you give them the handout, ask youth:

- Have you ever seen a movie or show where a teenager talks with an adult about their sexuality or sexual health? Did it help or hurt the teenager?
- Do you think that it is possible for an adult to be a safe person for a teenager to talk with about sexuality or sexual health?
- What kind of qualities might an adult need to have to be a safe person for a teenager to talk with about sexuality or sexual health?

Give the youth a copy of the handout. If the youth is comfortable with you, ask them questions related to the handout, such as “What sexual health topics would you like to learn more about?” and “Who are safe people you can speak to about this?” If you don’t have the kind of relationship where you can talk about sexuality and sexual health issues, talk through each part of the handout while exploring who a youth might be able to speak with to access accurate information. Lastly, follow up with youth to see if they have spoken to a safe person or to provide youth with a list of helpful resources such as national hotlines or local services. (Make sure you have vetted these resources to ensure they use trauma-informed approaches and provide accurate information.)

### ***Counselors***

Explore with youth the many topics that fall under sexual health, like abortion, anatomy, condoms, contraception, gender, intimate partner violence, relationships, sexual activities, sexual orientation, sexual trauma, sexually transmitted infections, pregnancy, and puberty, among others. You can also brainstorm situations in which talking about sexuality could improve one’s sexual health; for instance, contracting a sexually transmitted infection and reaching out for help finding a local agency that provides affordable testing, treatment, and education on STIs and practicing safer sex.

Ask youth to identify people in their life they would feel safe talking to about sexual health. Encourage youth to list at least one or two adults. Youth might be hesitant or distrustful due to past experiences with violations in confidentiality and autonomy. In these cases, it is important to validate youths’ feelings. Then discuss strategies to support them in identifying adults to build relationships with where they can feel safe.

One example is the volunteers who moderate the discussion boards on [www.scarleteen.com](http://www.scarleteen.com); using this platform can be a completely anonymous process, but it can also be a place to connect with trustworthy adults. Additionally, you could offer to introduce the youth to a professional you trust to be supportive of youth autonomy and confidentiality and who is not affiliated with your agency. Alternatively, you can help youth advocate for their sexual health by providing them with a list of resources to reach out to.

Ask youth how they can tell what makes some people safe to talk with compared to other people. Invite youth to describe what a sense of safety feels like to them. It is important to consider a youth’s past experiences seeking help. There may have been times when a youth’s sense of safety has deceived them, which has led to trauma or someone refusing to believe them about a trauma. Allow youth the space to process such feelings. Offer to create a safety plan in case their initial safe person is unhelpful or makes matters worse.

Lastly, have youth rate on a scale of one to five the chances of their feeling comfortable enough to talk about sexual health with one of the identified people or resources. Finally, ask youth why they chose that number instead of a lower number. This will encourage youth to think of the identified person or resource’s strengths.

## Group Conversations

In a group setting, the group leader should write each question from the handout on a separate piece of paper or sticky flip chart paper and hang them in different locations around the room. Have group members write their answers on Post-it notes and stick the Post-it notes on the appropriate question. Then, review the answers as a group and ask members to share what particularly stands out to them. Have group members offer mutual support by inviting them to share what they already know about the topics written on the Post-it notes. As group leader, help clear up any misconceptions group members might have about a topic and look for opportunities to spread awareness about available resources. If time permits, invite group members to share their current comfort level with talking to someone about sexual health and if it has changed by talking about it as a group. Be sure to shred everyone's Post-it notes after the session. In the following group session, begin by asking group members if they spoke to anyone about sexual health, whether it helpful, and whether they would do it again.

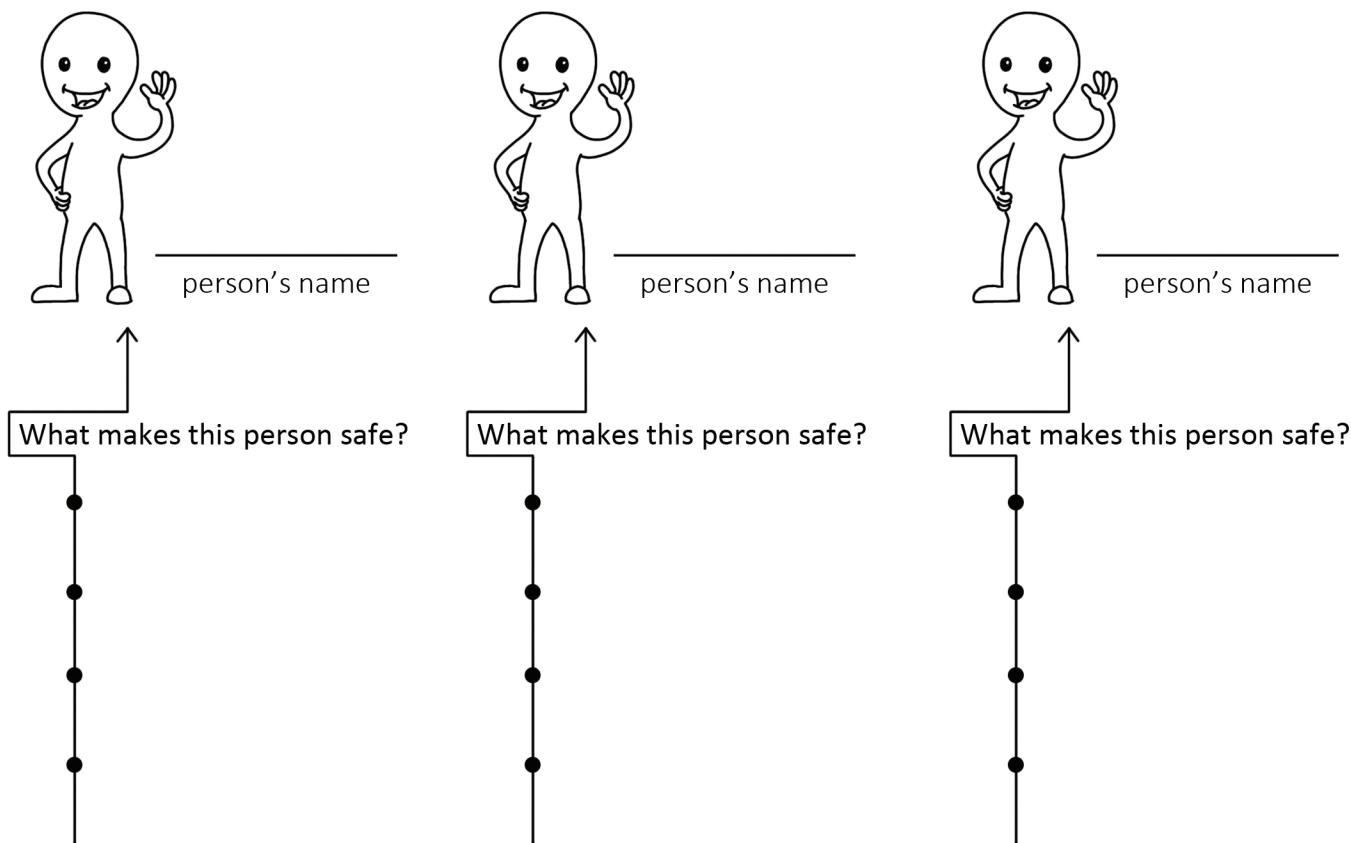
## Suggested Wrap-Up

Reiterate that it is okay if a youth does not currently have three caregivers that they trust to talk with about sexual health. Explore steps they may take to increase access to accurate information and trusted adults. Lead a group conversation with the following questions:

- What did you learn about yourself during this exercise?
- What are you hoping to learn more about regarding sexual health?
- Did your level of comfort with talking about sexual health change from this exercise?

# Safe People

Can you think of three people you feel safe talking with about sexual health and/or sexuality?



Rate the chances of you speaking with each person about sexual health and/or sexuality.

**1** hard pass!   **2** maybe?   **3** sure...   **4** yeah.   **5** oh, totally!

**1** hard pass!   **2** maybe?   **3** sure...   **4** yeah.   **5** oh, totally!

**1** hard pass!   **2** maybe?   **3** sure...   **4** yeah.   **5** oh, totally!

Now that you've thought about safe people to talk to, use the back of this page to write down at least two topics you want/need to talk about.

## Sexual Harassment

This is a simple handout that provides examples of what sexual harassment is, specifying four categories of harassment: digital, verbal, physical, and power imbalance. Youth who have experienced family violence, neglect, or sexual grooming often have a different understanding of safety, love, and consent. Some youth might interpret manipulation and coercion as affection and love. Do not act or appear shocked or frustrated if youth have a difficult time perceiving these behaviors as sexual harassment. This will only alienate them. Instead, remain kind and nonjudgmental. Giving youth more opportunities to process this information will help reinforce healthy behaviors.

**Note:** Remember that sexual harassment affects people regardless of their sexual orientation or gender identity. Sexual harassment is not only unwanted sexual behavior; it can also be pressure to conform to gender stereotypes, and non-conforming youth are often subject to the most intense sexual harassment (or sexual bullying).

### Objectives

- Identify behaviors that are considered sexual harassment
- Explore youths' beliefs regarding sexual harassment behaviors
- Present youth with an opportunity to create a safety plan

### Individual Conversations

#### *Caregivers / Case Managers / Direct Care Staff*

There are many ways you can introduce this handout. One way is to simply ask, "What is sexual harassment?" Discuss the youth's response and if appropriate ask a follow-up question, like "How can you tell when someone is being sexually harassed?" (Note: The correct answer is that only the person who is the target of a behavior can say whether it is sexual harassment or not. Sexual harassment is unwanted and unwelcome sexual behavior.) The youth's answer to this question is a great way to introduce the examples on the handout. You can tie these examples back to the "Columns and Shadows" handout to talk about why or how they are problematic in that framework.

Alternatively, you can initiate dialogue about sexually harassing behavior by using popular media such as movies, television shows, books, and music. Come with several examples and ask your youth if they have seen or heard about these examples. You may even have some example YouTube clips prepared for this session. After you have shown your clips, ask the youth if they can think of any additional popular media examples.

Challenge youth to critically think about times when they have seen sexual harassment in their daily lives at work, school, church, restaurants, on the street, etc. Discuss and process their examples, including their right to be free of harassment. Discuss how someone could file a harassment complaint at school, work, or in other environments.

Remember that this topic and handout may be triggering to some youth, so keep a trauma-informed lens on at all times. One way to allow the youth to keep a necessary distance from the topic is to talk about it in third person. This will allow youth to relate the handout's information to their life without ruminating on their own past trauma. Some youth might be motivated to use this handout as an opportunity to discuss their own experiences with sexual assault. It is important to be nonjudgmental and to validate the youth's experience. Do not victim-blame them.

If youth disclose harassment, assault, or abuse, always ask if they would like to file a police report. If CPS needs to be contacted, give youth a sense of control by asking if they would like to make the report with you by their side.

## **Group Conversations**

Because of the emotional content in this handout, it is difficult to use in a group setting. Instead, keep it for use in one-on-one conversations.

## **Suggested Wrap-Up**

Provide youth with a list of resources related to sexual harassment such as hotlines, informative videos, or advocacy services. Make sure that youth have the means to access the resources provided, such as access to the internet, a cell phone, or transportation.

Let youth know that you are available to talk more about this topic if they would like to. Below are possible questions to help youth think critically about the handout:

- How did this handout change your perception of relationships?
- Who can you reach out to if you experience sexual harassment?
- What information was new to you?
- Did the information resonate with you?

# Sexual Harassment

Some examples of sexually harassing behaviors are listed below.

## Digital Sexual Harassment

- Calling, texting, or otherwise trying to be in contact with someone all the time
- Sending someone sexual pictures or videos of yourself or someone else
- Tagging someone in a sexually explicit way

## Physical Sexual Harassment

- Following someone
- Giving a massage
- Making sexual gestures or facial expressions at someone
- Standing too close
- Staring
- Touching someone in a sexual way

## Power Imbalance Sexual Harassment

- Telling someone they have to be sexual with you in order to keep something bad from happening to them
- Telling someone you will use your power to give them something they want in exchange for sexual contact

## Verbal Sexual Harassment

- Asking someone out over and over again after you've been told no
  - Asking someone to be sexual with you after they've told you no
  - Calling someone a sexual term, including *gay*, *slut*, *bitch*, etc.
  - Sexual jokes or conversations that are too personal or explicit
  - Spreading rumors about what someone has done sexually, with you or anyone else
- From *UN|HUSHED: The Middle School Curriculum* (unit 5, session 3, p. 14) by K. Rayne and J. Smarr, 2019, Austin, TX: UN|HUSHED. Copyright 2019 by UN|HUSHED. Reprinted with permission.

## Notes

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## The Sexualitree

The Sexualitree is a tool developed by Sam Killermann and Dr. Karen Rayne to explore how people experience sexuality in different ways. This handout describes three different levels on which people learn about and experience sexuality: cultural, relational, and intimate. This guide is a brief introduction to using this handout. Visit [www.sexualitree.org](http://www.sexualitree.org) for extended details and examples.

### Objectives

- Understand the difference between “sex” and “sexuality”
- Learn how a person’s culture affects sexuality
- Reflect on what a person’s family and friends teach them about sexuality
- Consider the ways in which a person’s sexuality is influenced by people they are dating or having sex with

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

The Sexualitree can be used with and tailored for a wide range of youth. This handout can be broken down into two parts, both of which can be completed by caregivers, direct care staff, case managers, and counselors during the same session. However, professionals who are restricted by time can complete Part 1 and Part 2 at different times.

#### *Part 1*

One way to introduce the concept is to ask a youth how they would define the words “sex” and “sexuality.” Here are formal definitions you can use to support the youth’s ideas:

- **Sex:** This term can mean one of two things:
  - Sex can refer to a person’s anatomy and physiology and is usually defined as “female” or “male.”
  - Sex can also refer to physical acts of intimacy that usually involve parts of the body such as the vulva, vagina, penis, and breasts, and skin-to-skin contact. Many people think about penis-in-vagina intercourse when they hear the word “sex,” but the term can refer to other kinds of sexual activity as well.
- **Sexuality:** This term is defined in many different ways, but there are two primary approaches:
  - the kinds of sexual connections that people want to have, including their emotions about and their physical reactions to other people, and
  - the many ways in which a person expresses themselves as a sexual being, both in and out of relationships.

Sex is clearly part of sexuality, but it isn't the only part.

Give the youth a copy of the Sexualitree handout and look it over together. Pay particular attention to the three levels of sexuality:

1. **Roots:** Represent the cultural level of sexuality. This handout defines culture as "Everyone in your city, state, or country." A person's culture may include people who they identify with and people they do not identify with. The messages that our culture sends out are usually learned very young, and people usually know what their culture says about a topic, even if they disagree with it. Cultural knowledge and experience is very hard to change or shift, like the roots of a tree, and it forms a structure for everything that grows and develops later.
2. **Trunk:** Represents the relational level of sexuality. This handout defines relational as "Your family, your friends, and everyone else you know." These are the people you actually talk to and interact with. You may agree or disagree with these people on many different topics, but because you actually interact with them (as opposed to cultural influences), you can argue with and learn from them. Similarly, the trunk of a tree shifts direction and grows in unique and individual ways and is overall much more interactive than the roots.
3. **Leaves:** Represent the intimate level of sexuality. This handout describes intimate as "You and people you are dating or having sex with." These people will usually have a lot of influence over how you feel and think about sexuality, and may influence your physical, sexual, and emotional health. Leaves of a tree grow and change, just like a person's sexuality changes and how and with whom they are sexual changes over their lifetime.

Allow the youth to share their initial thoughts with you. Ask youth how this concept of sexuality compares to their own definition of sexuality. Proceed to Part 2 if time is available.

## **Part 2**

Next move on to talking about the elements of sexuality. There are potentially hundreds or even thousands of elements of sexuality, including anything that affects a person's sexuality. An element of sexuality may influence a person on zero, one, two, or three levels of their Sexualitree. This is to say, it may influence their sexuality on some, all, or none of their cultural, relational, and intimate levels of sexuality. Here are some examples of how the element of condom use could influence different people's Sexualitrees:

- Condoms might affect a person's Sexualitree roots if their religion says that using condoms is a sin. Condoms might affect another person's Sexualitree roots if their school hands out condoms for free, suggesting that they are a good thing to use in a sexual relationship.
- Condoms might affect a person's Sexualitree trunk if they find used condoms in their parents' bathroom trash. Condoms might affect another person's Sexualitree trunk if their friend had sex and the condom broke, and their friend was really worried.

- Condoms might affect a person's Sexualitree leaves if their partner has a latex allergy and they talk about finding latex-free condoms. Condoms might affect another person's Sexualitree leaves if their partner refuses to have sex without a condom.

As the list of elements on this handout indicates, there are many different elements of sexuality. You may find it useful to download a blank version of the Sexualitree from [www.sexualitree.org](http://www.sexualitree.org) so that your youth can include only those elements that are most relevant to them. You may also prefer to use the simpler, blank version with younger youths, so you can provide more verbal explanation.

## Group Conversations

This handout can also be completed in a group context. Allow youth to fill in their own Sexualitree. If they like, they can share their handout with the group or a partner. Reflect on how everyone's Sexualitree is unique. Notice similarities and differences in how group members are impacted by the elements. Discuss how youth can positively affect other people's Sexualitrees as a friend, family member, or intimate partner by doing things like promoting safe sex, being supportive, or setting boundaries.

## A Suggested Wrap-Up

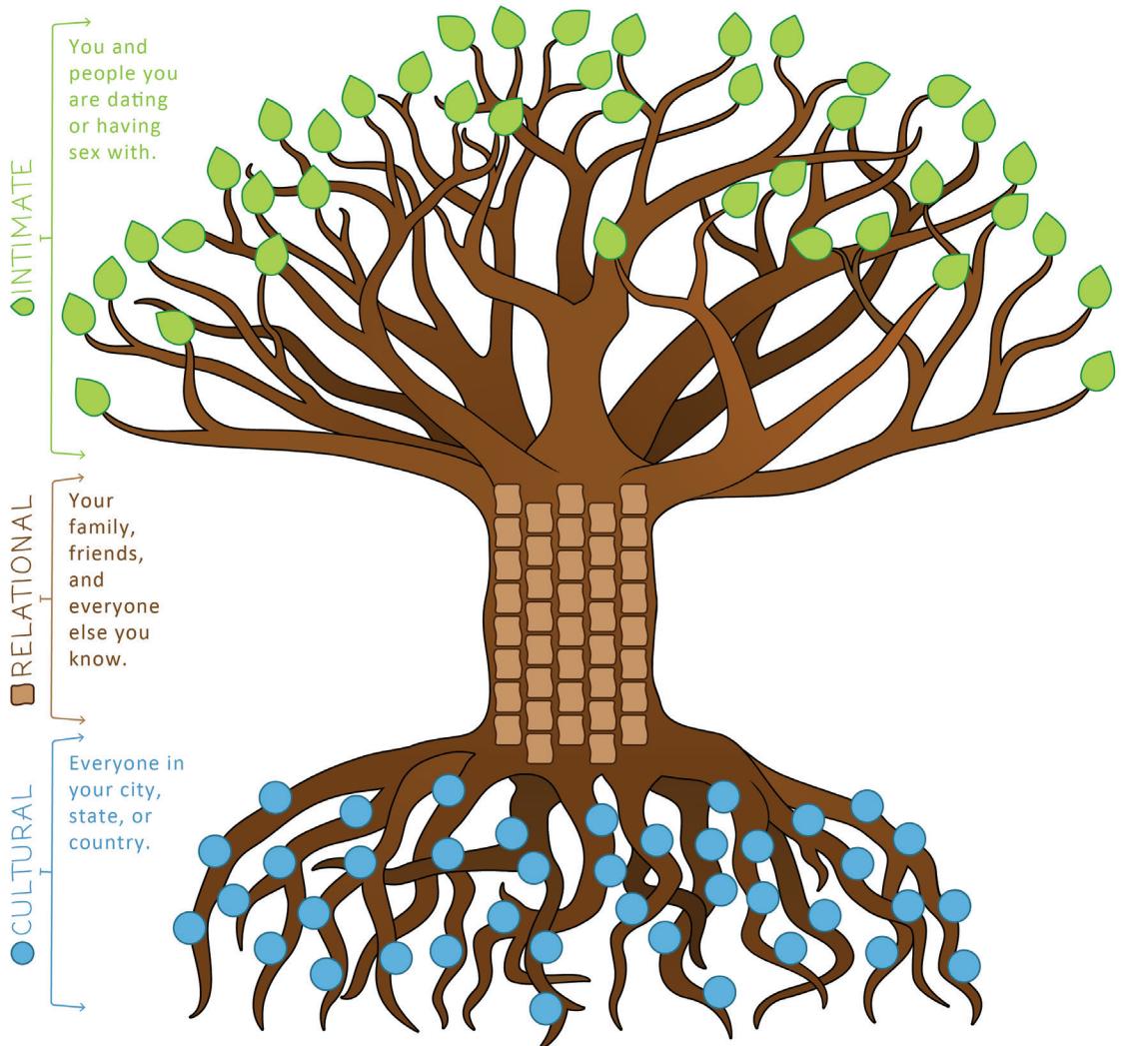
Either for homework or during the session, have the youth look at the elements at the bottom of this handout. Encourage them to think about whether and where these elements might fit on their Sexualitree.

Once you introduce the Sexualitree, you can use it in many different ways. For example, you might use the tree as an opportunity to discuss long-term goals, and how the youths' root systems and social structures are still forming and can be influenced by their choices. You can use this as a framework for talking about how to support their intimate relationships, both current and future. You can find additional ideas on ways to use the Sexualitree at [www.sexualitree.org](http://www.sexualitree.org). This handout is one that you can keep referring back to as the youth develops and explores their sexuality.

# THE SEXUALITREE

by **UN|HUSHED** & its pronounced **METROsexual**  
Poster v2.0

The Sexualitree is a way to see how we experience sexuality in different ways. Sexuality affects us on different levels of our lives, and each person uniquely.



3 levels of sexuality (Intimate, Relational, Cultural), 45+ different elements.  
Each bubble (green, brown, blue) can be filled in with any of the numbers below, representing the ways you experience various aspects of sexuality.

- |                         |                       |                          |                            |
|-------------------------|-----------------------|--------------------------|----------------------------|
| 1. abortion             | 13. family            | 25. medical theory       | 37. sexual anatomy         |
| 2. abstinence           | 14. fantasy           | 26. oral sex             | 38. sexual orientation     |
| 3. access to healthcare | 15. fashion           | 27. physiology           | 39. sexual response system |
| 4. age                  | 16. fetish            | 28. pornography          | 40. sharing                |
| 5. anatomy              | 17. gender            | 29. psychological theory | 41. skin hunger            |
| 6. body image           | 18. healthcare system | 30. puberty              | 42. STI prevention         |
| 7. caring               | 19. intercourse       | 31. race                 | 43. STIs                   |
| 8. communication        | 20. laws              | 32. rape                 | 44. technology             |
| 9. consent              | 21. liking            | 33. religion             | 45. vulnerability          |
| 10. contraception       | 22. loving            | 34. reproduction         | 46. _____                  |
| 11. disability          | 23. masturbation      | 35. risk taking          | 47. _____                  |
| 12. education           | 24. media             | 36. sex toys             | 48+ _____                  |



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## Social Media Discussion

The internet is an important part of our lives, and it is critical that adults discuss navigating the online world in a safe and healthy way. Responsible caregivers should discuss values, rules, and strategies for handling specific issues that will likely arise while online.

### Objectives

- Develop mutual understanding of rules related to internet use and social media accounts
- Articulate strategies to manage issues that arise during internet use

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Use the discussion guide as a starting point for a discussion about the internet and social media. If you are a caregiver who is in charge of the daily care of youth, you should also set clear guidelines with youth about social media and internet use. Age and maturity of the youth can drive decisions about guidelines. Regardless of the guideline that is set, youth should understand why that guideline is important even if they disagree.

Consider your answers to the following questions/topics before talking about them with a youth. Consider how your answers may or may not be flexible depending on the youth's age and input into the conversation.

Guidelines to set and discuss:

- Times when internet and social media are allowed
  - What times during the day are acceptable for media use?
  - Are devices allowed to be used after bedtime?
  - Is there a limit on screen time per day?
- Where devices should be stored during the times they are not in use
  - Should youth leave devices to charge in a particular location each night?
  - Is a device allowed to be taken to school?
- Access caregivers have to devices and accounts
  - Have the caregivers installed an app on the device that tracks its location?
  - Do caregivers have the ability to turn off the internet on the device?
- How caregivers may monitor accounts
  - Will the youth be required to accept a friend request from the caregiver?

- What should the youth do if they want to use a new social media platform?
- Can accounts be public? Or should they remain private?
- Will youth be required to share passwords with the caregiver?
- Will the caregiver periodically monitor account content or phone content?
- Rules about appropriate content
  - Who can youth accept friend requests from?
  - Who can have the youth's phone number?
  - Who can youth open attachments from?
  - What pictures can be shared?
    - None with nudity?
    - None taken in the bathroom?
    - None taken of siblings?
    - None taken of peers and posted without permission?
- What behaviors will result in restricted use of social media?
  - Humiliating others?
  - Lying about age?
  - Sharing contact information with strangers?
  - Meeting in person with people youth meets online?
  - Viewing pornography?
  - Threatening others?

## Group Conversations

In a group setting, the discussion guide can be used in a similar manner. Group facilitators can have youth brainstorm responses to the questions above, write their response to each top-level question anonymously on a Post-it note, and stick it to a piece of white paper or board. The group can then go through the questions and talk about strategies to address each issue.

## Core Information

There is a researcher named danah boyd (who prefers her name to be written in all lower case) who says that all social media: 1) Stays around forever, 2) Is easy to see, 3) Is easy to share, and 4) Is easy to search for. When you think about all the things you've posted on social media, are you okay with these four things being true, or are you worried about something you've posted being seen, found, or shared

forever? Have you posted more things you feel fine about or more things you're worried about?

Social media can be a fun and important part of people's lives. Especially when youth are in foster care or have moved homes, social media might be a good way to keep in touch with people. Like most things, though, there is both good and bad. Sometimes people make bad choices. What are some ways people might make bad choices on social media? (See 5e in the above section for ideas.)

Social media can be hurtful and a little scary. We know that once we post things, we can't really take it back, so it is important to think about the person we want to portray online. Sometimes it is nice to try out new personalities online, but regardless of who you portray, think about the core messages you want to send.

- What might happen if you use social media in ways that humiliate or hurt others?
- What are the best things about you that you want people to know?

Let's imagine we have a younger brother or sister who was starting to use social media. What rules would we encourage them to follow to stay safe? Where should they go if they need help? When should they ask for help?

## **Suggested Wrap-Up**

Follow up with youth by asking:

- How do you think you could share what you've learned today with your friends?
- How do you think you might talk with a friend if they were posting things online that made you worried?



# Social Media

## Things to think about

1. When can I be on the Internet?
2. When can I be on social media?
3. Where is my cell phone (tablet, computer, etc.) kept when I'm not using it?
4. Can anyone else other than me look at my cell phone (tablet, computer, etc.) or my social media accounts? Who? When? Why? How?
5. Can someone else turn off my Internet access on my cell phone (tablet, computer, etc.)? Who? When? Why?
6. What are the rules about who I can talk with on social media?
7. Who can have my phone number? When? Why? How?
8. Can I share pictures with other people? Who? When? Why? How?

## Trauma and the Body

This handout should be used to help youth have a better understanding about how their body is affected by trauma.

Trauma occurs when an experience is too intense and exceeds our brain's and body's capacity to cope. In an effort to protect oneself from future trauma, the brain and body create alterations in their normal reactions; for example, the brain could become more likely to interpret information as potentially threatening. This produces an overactive stress response, which includes the release of hormonal messengers that warn the body to prepare for a potential threat. Consequently, some individuals may experience intense emotions and physical sensations such as increased heart rate, distrust of people, or behavioral problems. Others might experience a disconnected response to trauma and experience feelings of dissociation or being outside of one's body. It is important to remember that everyone reacts to trauma uniquely.

### Objectives

- Understand the physical and psychological reactions to trauma
- Reflecting on how a person's own body is affected by trauma
- Explore ways youth can ground themselves when they are overwhelmed by their reactions to trauma

### Individual Conversations

This handout consists of two pages. Adults like caregivers, case managers, and counselors who have the time and capacity to complete both handouts in one sitting are encouraged to do so.

#### ***Caregivers / Case Managers / Counselors / Direct Care Staff***

Begin by talking about what trauma consists of. Ask the youth what they think. Depending on the age and development of the youth, consider which parts of the Trauma-Informed Sexual Health Framework from the introduction section of this handbook might be useful to share with them.

After this introduction, move to the handouts and ask youth to consider how they might fill out each of the five boxes. Inform youth that it is common for some people to experience strong physical sensations as a response to past trauma. These physical sensations occur whenever our brain has interpreted something as a potential threat, which can put us on the defense multiple times a day. Use the labelled diagram from the second page to review all the different ways our body might feel trauma. Give youth an opportunity to add any other physical sensations, such as sweaty palms or a feeling of being outside one's body.

Provide youth with the second page and different colored markers or crayons. Ask youth to reflect on how their body feels trauma and to color the body accordingly. Tell youth that they can share this

activity with you or keep it private. (Alternatively, you can encourage youth to share it with an adult they trust such as their counselor.) Encourage youth to consider frequency, intensity, and duration of the physical sensations. Be sure to normalize youth's psychological and physical reactions to trauma. Explore what coping strategies youth are already using when they feel these sensations come up. Collaborate on other coping strategies that youth can experiment with.

### ***Counselors***

Counselors and other professionals skilled in trauma can also use the handouts to help youth think about their reactions to trauma in a more concrete manner. It also encourages youth to identify a supportive person to talk to about their trauma reactions. Counselors should have good rapport and trust built with youth before exploring their trauma reactions. If youth feel uncomfortable working on this handout with you, offer to give them a copy to look over and reflect on in private. Let youth know that if they change their mind you are happy to talk more about the handout later.

### **Group Conversations**

When using these handouts in a group setting, review the handouts and the Trauma-Informed Sexual Health Framework section from the introduction to this handbook before the group session to broaden your own understanding of trauma. Inform youth that it is common for some people to experience strong physical sensations as a response to past trauma. These physical sensations occur whenever our brain has interpreted something as a potential threat, which can put us on the defense multiple times a day. Then write, "How do people react to trauma?" on the board, and ask youth to brainstorm different reactions to trauma. Group leaders can also integrate the information they reviewed from the introduction section to deepen the exercise.

When moving to the handout, use the second page diagram to review the different ways people's bodies might feel trauma. Give youth an opportunity to add any other physical sensations, such as sweaty palms or a feeling of being outside one's body. Finally, provide youth with colored pencils or crayons and encourage them to color or draw where their body feels trauma. Invite youth to share their work with a partner or to talk with a partner about how other people's bodies might feel trauma.

Encourage youth to think more about the ways their own body feels trauma by utilizing the first page of the handout. Write the five prompts from the handout on separate sheets of paper and hang them throughout the room. Invite youth to anonymously write their answers on Post-it notes and stick them by the corresponding prompts. Once youth are done, review answers together as a group. Reflect on similarities between the Post-it notes and invite youth to share their own thoughts and feelings.

End group by facilitating a mindfulness or grounding technique with the group.

### **Suggested Wrap-Up**

Ask youth what they plan to do with this new understanding of trauma reactions. Be sure to check in with youth on how they are feeling at this moment. Give youth time to ground themselves before leaving, especially if they are experiencing unpleasant emotions or physical sensations.

To help youth foster insight into how they experience trauma, provide a few blank handouts so they have the opportunity to observe how they feel trauma differently over time or in response to certain events. If youth are interested in experimenting with different coping strategies, instruct youth to complete a blank handout when their body is feeling trauma. Then complete another handout after trying out a new coping strategy. The youth can then compare the two to see if there were any changes. Youth can use this technique to compare the effectiveness of different coping strategies by keeping these body maps. Encourage youth to share this information with their counselor or another safe adult that they feel comfortable sharing with.



# Trauma and the Body

## An Introduction to Human Sexuality

Each person's body experiences trauma differently. Some people are hyper-attuned to their bodies, and feel a surge of energy run through their body such as a faster heart rate, sweaty palms, or sudden anger. Others might be disconnected from their bodies and become unaware of physical sensations and/or their surroundings. This is called a trauma response. Take a moment to reflect on how your body experiences trauma, then answer the questions below.

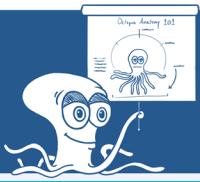
My physical reactions to trauma include:

My mental/emotional reactions to trauma include:

My trauma response happens when:

I can talk about trauma with:

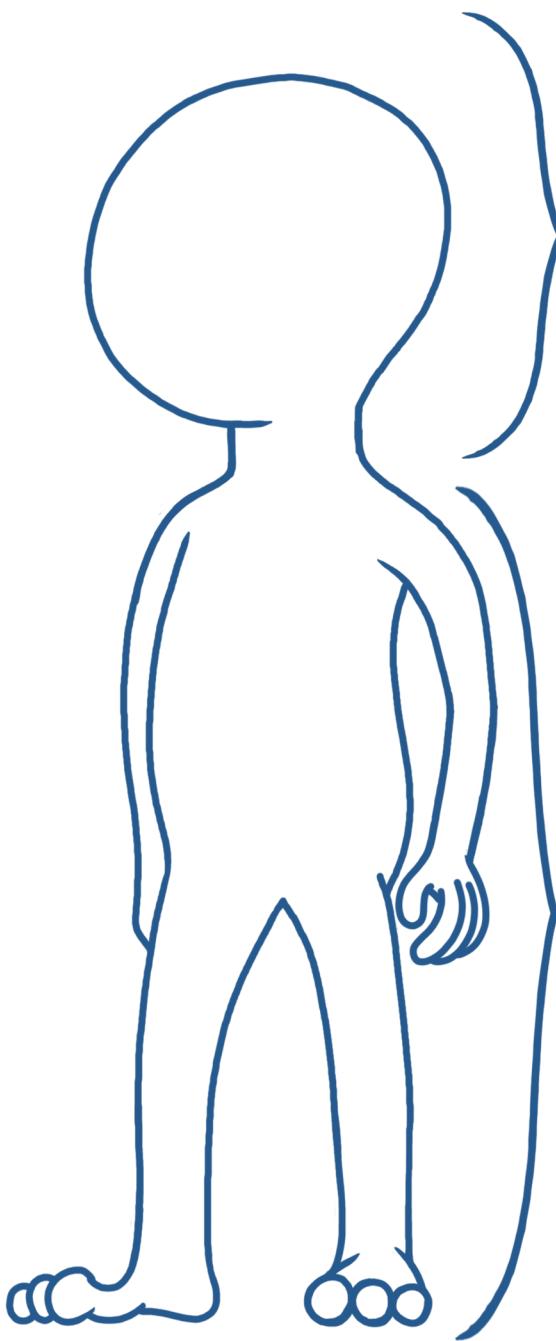
When I talk about trauma, I feel:



# Trauma and the Body

## An Introduction to Human Sexuality

Below are some common reactions to trauma. Can you think of any others?



### Mental/emotional feelings:

- abandoned/alone
- angry
- anxious
- hurt
- intrusive memories
- isolated
- out of control
- overwhelmed
- restless
- sad
- stressed
- unsafe

### Physical feelings:

- clinched jaw
- faster heart rate
- frozen
- furrowed brow
- hard to breath
- headache
- muscles tighten
- nauseous
- need to run
- numbness
- stomach pain

## Notes

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## What Is Sex?

This tool is easy to use with youth who are in middle and high school. Many people think they know the answer to the question “What is sex?” However, the answers vary substantially based on many different factors, such as age, biology, socioeconomic class, peer group, religion, race, etc. This handout is a simple way to introduce the idea that sex means different things to different people. It is a good idea to check in on your personal biases prior to working through this handout with youth. Understand beforehand that you will have different opinions on the definition of sex from some youth.

### Objectives

- Encourage youth to be thoughtful about sex and the words they use to describe sex
- Empower youth to define what sex means to them

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Begin by saying that lots of people disagree about what “sex” means. Ask youth what it means to them. Many people may assume they know the answer, but few have ever actually been asked the question. After your opening question, give the youth a copy of the handout to complete on their own. Let them know that there are no wrong answers or judgments for their answers. This is a brainstorming and processing activity, so allow them to explore it in their own way.

#### *Counselors*

Take the exercise further by exploring whether all behaviors that the youth define as sex share an equal level of intimacy. Additionally, youth who experience trauma might exhibit hyposexuality or hypersexuality (extremely high or low interest in sexuality). It is important to validate and normalize youths’ experiences while processing how sexual trauma can influence one’s boundaries with others.

### Group Conversations

If you are working with a couple, family system, or group, you can give this handout to each person to complete individually and then share their responses with the others. Of course, whether or not to use this activity depends on the group you are working with. If you choose to do this activity with a group, remember to state that there are no wrong answers or judgments even when there are disagreements.

## Suggested Wrap-Up

End the conversation with questions like:

- Do you think it's possible for people who are dating each other or even having sex with each other to disagree about the meaning of the word sex?
- How do you think disagreeing about what sex is might impact a relationship?
- Why do you think people have different definitions of sex?
- How did you determine what your definition is?
- How do you think you learned what your definition is?

Discuss youths' answers and encourage them to think about the activity and to explore their own definition of sex. Explain to them that their definition can, and probably will, change over time and that is normal.

## What Is Sex?

|                                       | <b>Yes</b> | <b>No</b> |
|---------------------------------------|------------|-----------|
| Hugging                               |            |           |
| French kissing                        |            |           |
| Getting sexually aroused              |            |           |
| Rubbing together with                 |            |           |
| Masturbating                          |            |           |
| Having an orgasm                      |            |           |
| Touching sexually without intercourse |            |           |
| Having oral sex                       |            |           |
| Having penis-vagina sex               |            |           |
| Having anal sex                       |            |           |
| Not having sex after having had sex   |            |           |

## Notes

## What's Your Identity?

The first two handouts here describe many, although not all, of the ways in which people identify in regards to their gender identity and sexual orientation. The third, blank identity person handout is included so that youth can visually represent their own identities. Youth may find these handouts particularly useful if they are coming to understand their own gender identity and sexual orientation. This can happen before, during, or after puberty. For some people, it will happen in adulthood or even during older adulthood. Youth may also find these useful if they are trying to understand and be supportive of a friend or family member who is grappling with their own identity or orientation.

If you are unfamiliar with any of the language used in these handouts, or the concepts behind them, read through the related sections in “All About Sexuality” and the two dictionary handouts. As an adult who works with youth, the most important thing you can do to support youth who either identify as LGBTQ+ or are questioning their identity is to accept them, listen to them, and witness and validate them and their process.

### Objectives

- Learn the definitions of gender and orientation words
- Consider the elements of gender and orientation
- Promote safe space for youth to reflect and explore their own identity

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

The gender and orientation handouts have three parts: 1) an outline of a person with definitions of the components of gender identity, 2) an outline of a person with definitions of the components of sexual orientation, and 3) a blank outline. When introducing the concepts of gender and orientation to a youth, always start with the first two handouts. You may decide to share both or only one of these two handouts depending on the specific needs and interests of the youth you are working with. These exercises can be completed by caregivers, direct care staff, case managers, and counselors who are willing to be compassionate and nonjudgmental toward youth and their identities.

#### *Case Managers / Direct Care Staff*

For direct care staff and case managers with limited time, Part 2: Drawing Your Identity can be given to the youth to complete by themselves.

#### **Part 1**

Tell youth that knowing who you are takes time; there is no reason to rush the process. The media gives mixed signals about what gender and sexual orientation are, often suggesting that they are easy to understand and explain and that someone is “supposed to” understand themselves fully either

before or during adolescence. But many people experience gender and sexual orientation differently from this media portrayal, and many people experience changes in their gender and sexual orientation over their lifespan.

To account for the real-world difference from the media, before giving a youth either of the first two handouts, talk with them about words. If you will be talking primarily about gender, ask them how they might define “gender identity,” “gender expression,” and “biological sex.” If you will be talking primarily about sexual orientation, ask them how they might define “sexual identity,” “behavior,” and “attraction.” Validate the youth’s thoughts even if they define the ideas differently than the handout does. This section is not about being right; it is about exploring ideas related to identity.

Provide either the gender or the orientation handout to the youth and read the definitions together. Take time to talk about and process what each term means. Talk about what the spectra might mean. Think of examples together of ways people might put themselves on different places on the spectra. It is likely that the youth will have questions concerning one or more of the definitions. If you aren’t sure of the answers, you may look to the information in “All About Sexuality,” the “Gender Dictionary” or “Orientation Dictionary” handouts, and finally the “Additional Resources.”

Depending on the age and maturity of your youth, you may provide them with some of the resources to read on their own. After they have a solid understanding of the terminology, encourage them to make a mark on each of the three spectra (and, if you are looking at the gender handout, to check one of the boxes in the “Sex Assigned at Birth” category) so that the handout describes either their gender or their sexual orientation. Let the youth know that this is personal and that they will not have to share their answers with anyone, including you, unless they choose to.

After discussing either the gender or the orientation handout you may move on to the second one if the youth is engaged and interested in talking more, or you may keep the next one aside for another time.

## **Part 2**

The third handout allows the youth to explore their identity via their right brain in a safe environment. You will need to have crayons, colored pencils, or other art supplies available.

Encourage the youth to look at the gender and/or sexual orientation handouts to inform them as they create a visual representation of their gender identity and/or sexual orientation on the blank “Gender Outline” handout. They can do this through colors, shapes, words, and anything else that comes to mind. Allow the youth time to do this with minimal interruptions. Once they have completed their identity drawing, invite them to share it with you. If they do not want to, that is also okay. If your youth does share, describe what you see in their drawing (like “I see a lot of bright colors and a motorcycle”) rather than giving an evaluation of it (like “Your drawing is so good”) and thank them for sharing it with you.

Make sure the youth knows that identity development is a process and not something that will happen all in one day. Encourage them to take the handout and explore it on different days and maybe do another drawing. They may be interested in doing the activity together with a friend or a partner.

## Group Conversations

In settings that perceive and discuss LGBTQ+ identities as negative, problematic, sinful, or otherwise denigrating ways, youth are likely to feel safer completing this handout privately rather than in a group setting. However, when group dynamics allow for it, these handouts are powerful to read and discuss in a group setting.

In a safe group setting, begin by reminding youth of your agreements regarding respect, acceptance, and confidentiality. Ask the youth for definitions for all of the words on both the gender and sexual orientation handouts. Pass out both of the handouts and discuss what the spectra mean. Next, explain the third handout to youth. Tell youth that they can complete all of the handouts outside of the group session if they wish to, but make sure they have plenty of art supplies and copies of the blank “Gender Outline” handout so that they can experiment. It is often a useful bonding activity for you to take part in the art alongside the youth.

Before ending the session, inform youth that you have designated an area for people to hang up their finished handouts if they would like. Having a designated space such as a hallway for youth and staff to proudly hang their “Drawing Your Identity” handouts can promote inclusivity in residential or agency settings.

## A Suggested Wrap-Up

Whether the youth shares or not, here are some helpful questions you may ask:

- How did you feel while you were drawing (or thinking about) your identity?
- Did you learn anything new about yourself through talking about the definitions of these words or through the drawing activity?
- Will you think about anyone else differently based on a better understanding of gender identity and romantic and sexual attraction?

## What's Your Gender?

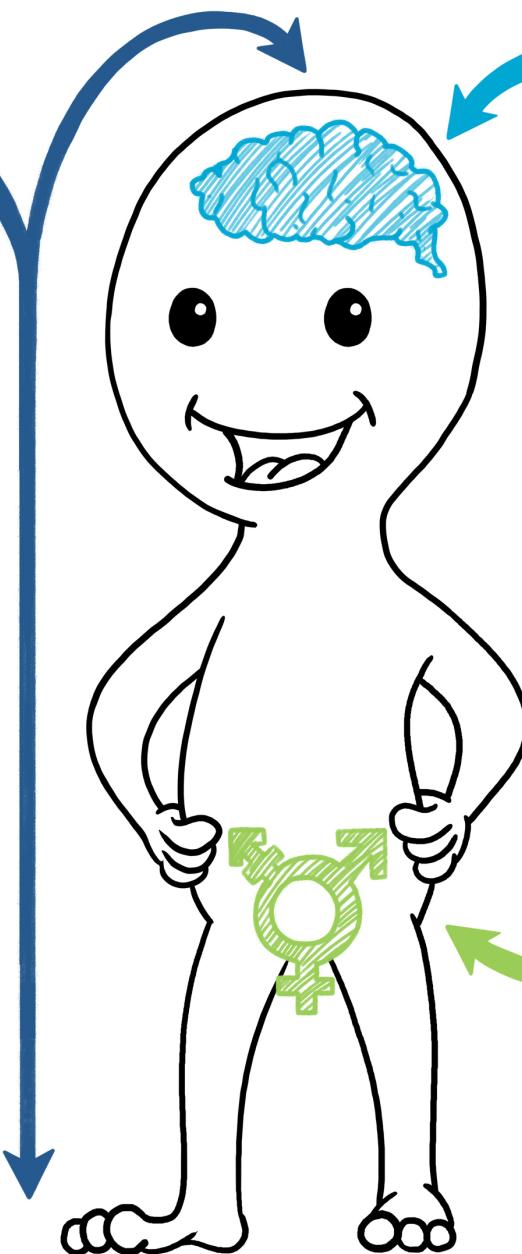
### Expression

The way(s) that a person shares information about their gender through their hair, clothes, makeup, etc.



femininity  
 masculinity

\*feel free to spiff up your person or doodle a new one below!



### Gender Identity

A person's internal sense of how they relate or do not relate to the social constructs that their culture aligns with the sex they were assigned at birth.



woman-ness  
 man-ness

### Biological Sex

A complex group of physical traits that are assigned to male, female, and/or intersex.



### Sex Assigned at Birth

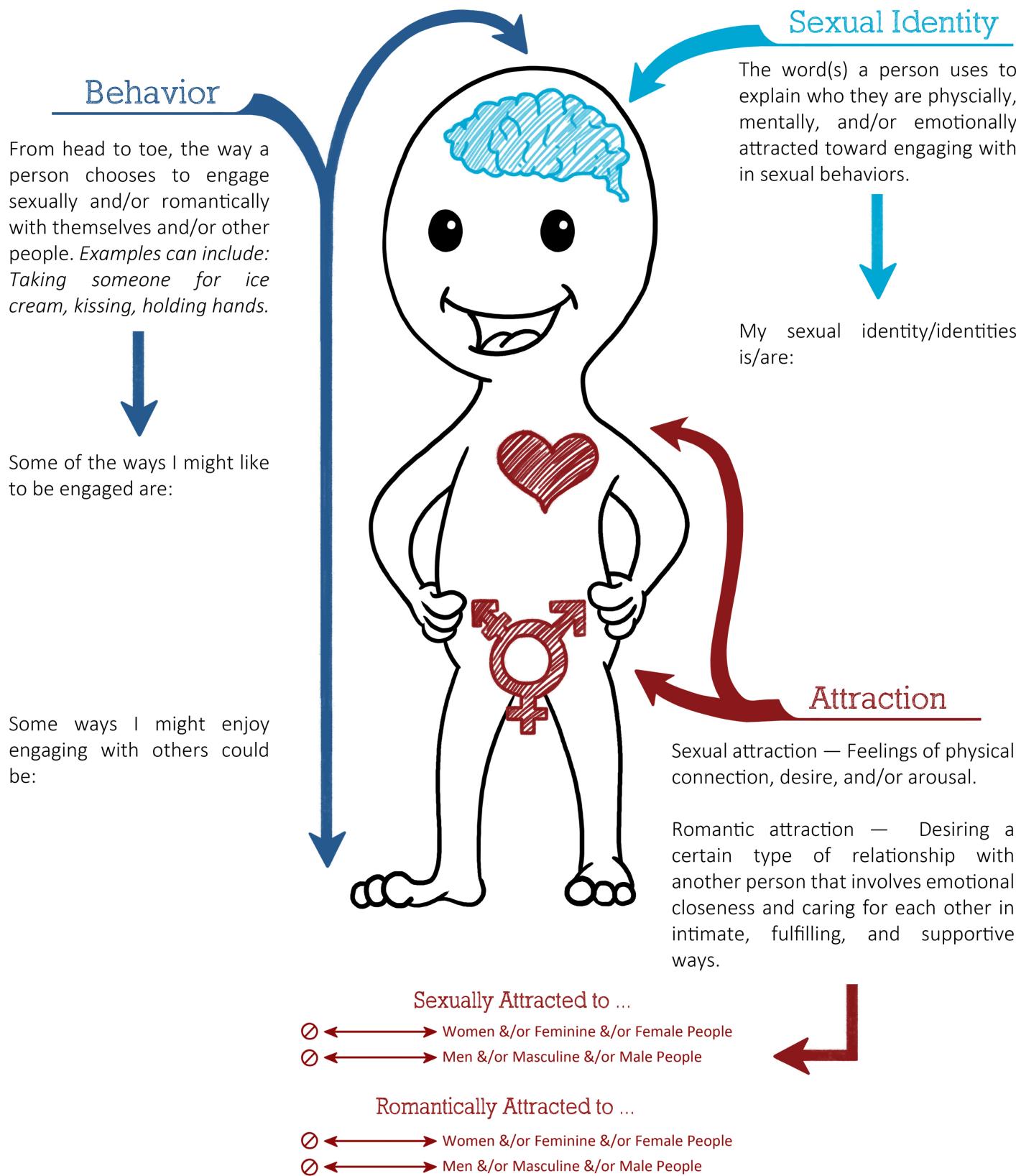
female     intersex     male



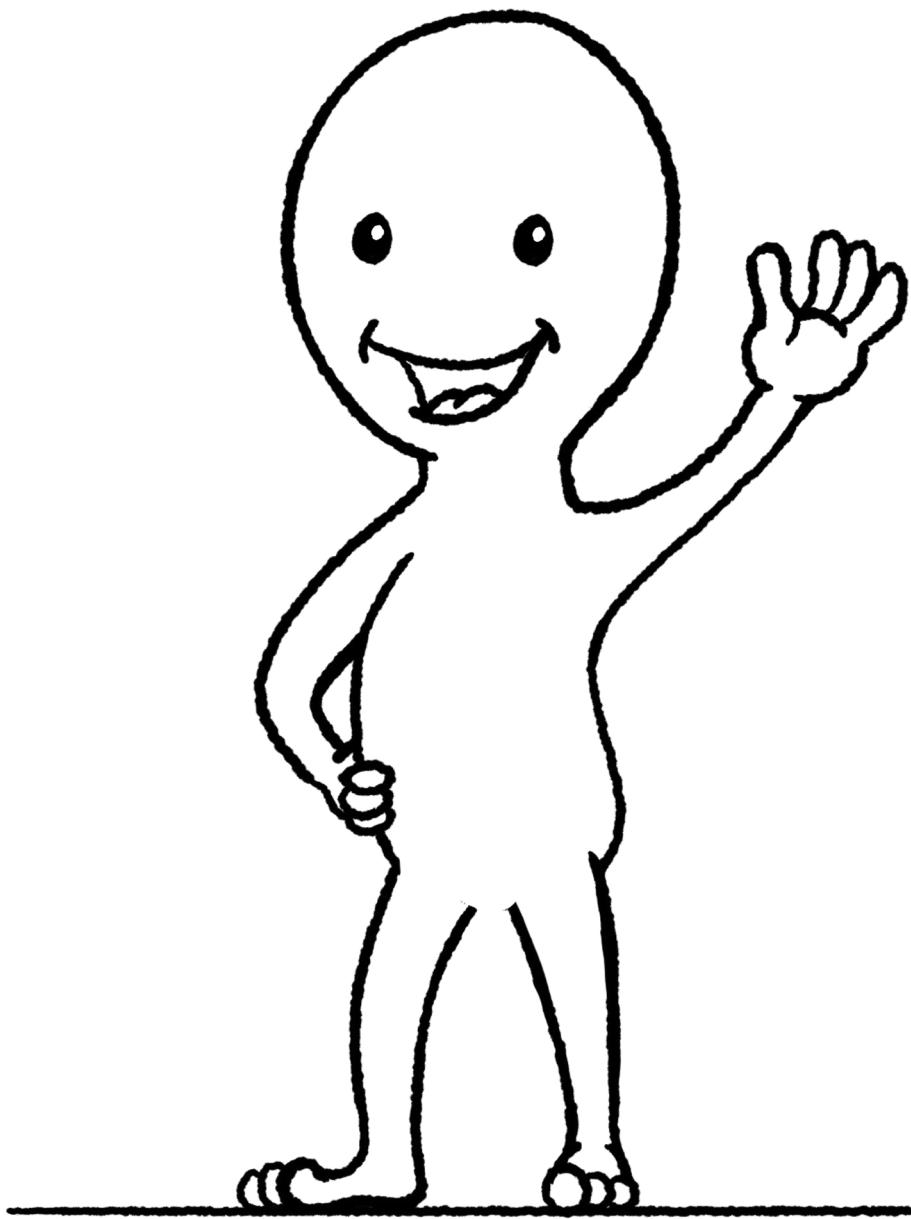
### Anatomical Traits

female-ness  
 male-ness

## What's Your Sexual Orientation?



## Gender Outline



## Young Parents

Many beliefs about teen pregnancy are shameful and stigmatizing, which can affect young parents' interactions with and perceptions of themselves, others, and society. This tool was created to help professionals give young parents an opportunity to express how others' beliefs impact youths' self-esteem and their interactions with others—including navigation of sexual health services. It can also serve non-parenting youth as they consider their own biases around young parenthood. Professionals should emphasize a youth's strengths, encourage problem solving, and provide psychoeducation when appropriate. When speaking to youth, be mindful that their parents might have been young parents themselves who were stigmatized by others' beliefs.

### Objectives

- Reflect on youths' reactions (thoughts and feelings) to statements about young parents
- Learn whether youth agree or disagree with beliefs about young parents
- Explore how beliefs about young parents impact youth's interactions with others
- Explore how beliefs about young parenthood could impact youth's sexual health

### Individual Conversations

#### *Caregivers / Case Managers / Counselors / Direct Care Staff*

Ask nonparent youth for their feedback on the handout. Give them the handout and ask if they agree or disagree with the beliefs listed on it or if any particular belief stands out to them. Continue to use the handout as a prompt to help youth explore how others' beliefs can impact their self-esteem, how others treat them, and their sexual health.

Ask youth if they can think of any stereotypes about young parents. Explore whether these stereotypes assume positive, effective parenting by young parents or not. Discuss why these stereotypes of young parents might exist. Lastly, ask whether youth agree with the statements as listed or if they have a more negative outlook on young parenting. Invite them to discuss why they hold these beliefs and, if their beliefs are primarily negative, what it might take for them to have a more positive outlook on young parenting.

#### *Caregivers / Case Managers / Counselors*

You can use this handout with young parents to explore how their beliefs about young parenthood have changed since parenthood, what their current goals are now, and how these beliefs affect their goal attainment. If youth is interested, connect them to appropriate services (sexual health care including birth control, child care, domestic violence services) that provide support to young parents as they work toward their goals.

### ***Case Managers / Counselors***

Depending on developmental appropriateness, you can continue the conversation with youth by discussing how system structures and cultural expectations perpetuate certain beliefs. Give youth space to share how their own identity, race, able-bodiedness, sexuality, or other elements of their identity have further influenced their interactions with others, including how they have navigated systems or obtained resources. The relationship between trauma and the concepts in this handout may be explored with counselors who are appropriately trained.

### **Group Conversations**

Designate one side of the room to represent “yes” and the other side to represent “no.” Inform youth that you will read a belief out loud. If they have heard the belief before, youth should walk, dance, or hop (depending on the energy levels of the group) to the “yes” side of the room. Conversely, if they have not heard the belief before, they should move in a silly way toward the “no” side of the room. If there are low-mobility youth in the group, invite everyone to do something that everyone in the group can do, like give a thumb’s up or a thumb’s down up to indicate whether they’ve heard the belief before.

Next, ask youth if they agree with each belief and have youth respond by moving to the appropriate side of the room. Give youth an opportunity to share why they agree or disagree with the belief. Ask youth how these beliefs impact their own thoughts, feelings, and actions. Continue to read out each belief and continue this format. The silly action can be switched depending on group members’ enthusiasm.

### **Core Information**

- 1. Young parents can't perform well in school:** Research suggests that becoming a young parent can lead youth to reevaluate their priorities and increase their aspirations related to grades, attendance, and graduation. However, competing responsibilities, school policies, and lack of support can hinder young parents from achieving their goals.

Suggested Questions:

- How did your beliefs toward school change when becoming a parent?
- What types of support would help you reach your goals?
- Does your school know you are a young parent? How does that affect your interactions with school?

- 2. Young parents' lives are ruined.** Becoming a young parent is NOT the end of the world, though it can sometimes feel that way. Young parents can still achieve their dreams.

Suggested Questions:

- How have your goals changed since having a child?

- What would you not change about becoming a young parent?

**3. Teenagers can't take care of babies.** Many young parents in the child welfare system have had to grow up very quickly in response to adversity. Be mindful that some youth might have been taking care of themselves and others long before becoming a young parent.

Suggested Questions:

- What are strengths that young parents have when it comes to parenting?
- How are young parents similar to older parents?

**4. Becoming pregnant that young must have been an accident.** Accidents do happen, especially if youth have not been taught about birth control or contraception. However, consider that youth might have become pregnant as a result of trauma. Sometimes youth are motivated to become parents for different reasons, such as being a better parent to a child than their parents were to them, or refusing to abandon a baby like others have done to them. Professionals should remain nonjudgmental no matter the reasoning behind youth becoming young parents.

Suggested Questions:

- What are different reasons why youth might decide to have a child?
- How does one's values impact this belief?

**5. Young parents will never be as successful as teens without kids.** Youth can still accomplish their goals if they are parents. It is important to encourage young parents to define what success looks like for them and help them create tangible goals toward it.

Suggested Questions:

- How do you define "success"? Has this definition changed since becoming a young parent?
- What type of qualities does a successful person have?
- How does being a young parent give you an edge toward success when compared to teens without kids?

**6. It is okay for young parents to ask for help.** Young parents might not always feel safe enough to ask for help, especially if they are unaware of support services or feel isolated from friends and family. Cultural beliefs and past experiences can influence a youth's perspective on seeking out help.

Suggested Questions:

- What beliefs do you have about asking for help? How does this affect you?
- Who are people you can go to for help?

**7. Young parents don't know how to use birth control.** Female youth could have had negative experiences with birth control, such as reproductive coercion in past relationships. Additionally,

some residential treatment centers have policies mandating young women to take birth control regardless of sexual activity.

Suggested Questions:

- What do you know about birth control and family planning?
- What are the benefits and disadvantages of taking birth control?

**8. Young parents will not stay together.** It is common for placement policies to require young mothers to switch placements when they become pregnant. Youth might express feelings of grief or resentment because of the loss of relationships. Transitions like this can be traumatic for youth.

Suggested Questions:

- What do healthy relationships look like?
- How has becoming a young parent affected your relationships with others?

**9. Young parents cannot be queer.** Heterosexual, bisexual, and lesbian adolescent females (ages 15–20) experience similar chances of becoming pregnant. However, bisexual and lesbian adolescent females are more likely to experience unwanted sexual contact than heterosexual adolescent females.

Suggested Questions:

- What do you know about sexuality and gender?
- What supports are available to young parents who are queer?

**10. Young parents are less responsible than teens without kids.** Adults can have different perceptions of young parents. Some adults will perceive youth as irresponsible and blame them for becoming parents. Other adults could perceive young parents as more responsible than teens without kids and place unfair standards on them.

Suggested Questions:

- How were adults' perceptions of you affected when you became a parent?
- What do you wish teens without kids understood about responsibility?

## Suggested Wrap-Up

Invite youth to share about:

- How did you feel during this exercise?
- What beliefs of yours were challenged during this exercise?
- Did you learn anything new about yourself or other group members?

## Young Parents

**DIRECTIONS:** Below is a list of beliefs that some people hold about young parents. Read the following statements and think about whether you agree or disagree, and why.

- Young parents are successful in school.
- Young parents can achieve anything.
- Teenagers make the best mothers.
- Becoming pregnant young must have been planned.
- Young parents are usually more successful than teens without kids.
- It is okay for young parents to ask for help.
- Young parents have reproductive rights.
- Young parents usually have healthy relationships.
- Young parents can be queer.
- Young parents are more responsible than teens without kids.



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## Additional Resources

The resources included here are merely a beginning. Indeed, even the list of topics is incomplete.

Creating a truly comprehensive list of high-quality resources about sexuality would take far, far more space than this handbook can provide. The authors included are often prolific; if you like what you find here, you can look for their other writing, speaking events, and training. We encourage you to continue to read, research, and expand your knowledge of sexual health and sexuality. If we've missed your favorite resource, let us know about it! Contact us at [info@unhushed.org](mailto:info@unhushed.org). We may include your idea in the next edition.

### An Introduction to Sexuality Education

Rayne, K. (2017). *Help Your Kids with Adolescence: A No-Nonsense Guide to Puberty and the Teenage Years*. DK.

This is a typical DK publication, heavy with graphics and icons to support the content. This book is designed for parents or other adults who want to read alongside children ages nine to twelve to support their understanding of the incredibly wide range of topics that preteens grapple with. From the internet to families to a healthy mind and body to sex and sexuality, this book covers many of the most difficult topics out there.

Zaloom, S. (2019). *Sex, Teens, and Everything in Between: The New and Necessary Conversations Today's Teenagers Need to Have About Consent, Sexual Harassment, Healthy Relationships, Love, and More*. Sourcebooks.

Zaloom's book provides the tools needed to have meaningful conversations with teens to promote a healthy sexuality. This book provides discussion questions to use when speaking with youth to help guide them into making safe and informed decisions about their sexuality.

### Bodies

Aldersey-Williams, H. (2014). *Anatomies: A Cultural History of the Human Body*. W.W. Norton & Company.

Aldersey-Williams writes a beautiful novel detailing historical and cultural aspects of the human body. Through great literature, philosophy, and art, the body is understood as a complete work capable of greater things than any individual part could achieve. Not a medical textbook, this book invites the reader to explore their understanding of the parts of their own being and the cultural meaning we've placed on them as a society.

Malacrida, C., & Low, J. (2016). *Sociology of the body: A reader* (2nd ed.). Oxford, United Kingdom: Oxford University Press.

This is a collection of classic and new academic articles about the body. There are sections covering topics from children to medicine and from incarceration to body size in thoughtful and unique ways. The articles may provide insight for clients who are grappling with body issues, particularly if they have connections to one of the highlighted identities.

Viloria, H. (2017). *Born both: An intersex life*. New York, NY: Hatchette Books.

This personal account of what it means to be intersex explores the cultural, social, and sexual journey. Meant to inform the reader about the biology of female, male, and intersex, Viloria brings her personal story into the open, in a compelling and expanding book.

## Child Welfare

Lash, D. (2017). *When the Welfare People Come*. Haymarket Books.

Spurred by his own experience working in the child welfare system, Lash provides a critical look at the child welfare system from a historical and political perspective. He introduces the perspective of families and youth who have experienced life in the system to explore how current practices regulate rather than strengthen families.

## Children's Books

Books are great resources for helping children and youth absorb information about sex and sexuality. Before you share a book with a youth, we encourage you to read through it first, whenever possible. This will allow you to be prepared for some of the questions and thoughts the youth might have.

Caregivers should keep in mind that not all children's books are created equal! In particular, there are very few books for young ages that talk about bodies outside of a boy/girl framework. Some components of these books may still feel useful in explaining difficult concepts to children, but we encourage caregivers to reinforce ideas about diversity as they read with young children. We have included a list of books here that you would likely find at a local bookstore and grouped them by rough age ranges. We have noted any limitations or potential problems that caregivers might want to consider prior to reading or purchasing a particular book.

### ***Toddlers and preschoolers***

Harris, R. H. & Bernard, N. (2011). *Who Has What? All About Girls' Bodies and Boys' Bodies*. Bee Productions.

This is a picture book of two characters, Nellie and Gus, who talk about similarities and differences between girls' and boys' bodies in an attempt to convey the message that all bodies are good.

Given the focus, there are limitations of this book, beginning with the statement that babies are born as either girls or boys. Although a penis and scrotum are identified, external female genitalia is described only as “an opening to a vagina.”

Harris, R. H. & Bernard, N. (2013). *What's In There? All About Before You Were Born*. Bee Productions.

Two characters, Gus and Nellie, ask questions about their mother’s pregnancy and the birth of their new sibling. The narration explains the development of the fetus and childbirth. This book presents a two-parent family headed by a heterosexual couple. It discusses pregnancy and childbirth from a gendered perspective and states that boys do not have a uterus.

Neilson, E. (2020). *Can I Give You a Squish?*. Dial Books.

A mer-boy named Kai learns about body boundaries and consent when interacting with his oceanic friends. Kai discovers alternative ways to greet his friends while being mindful of their comfort with physical touch. This book is designed for children ages three to seven.

Saltz, G. & Cravath, L. A. (2005). *Amazing You! Getting Smart About Your Private Parts*. Penguin Group.

This picture book introduces children to the concept of private parts and discusses anatomy, including penises belonging to boys and vaginas belonging to girls. It provides basic information about reproduction that is also narrowly defined as something occurring between a man and a woman.

Silverberg, C. & Smyth, F. (2012). *What Makes a Baby*. Seven Stories Press.

This picture book presents basic information about bodies and reproduction. It is the only book for young children we know of that presents this information from a gender-inclusive perspective. The authors have an online guide that is available for grown-ups to use to help read through the book with their children.

Stinson, K. & Collins, H. (2006). *The Bare Naked Book*. Annick Press.

This picture book introduces very young children to body parts, starting with hair, teeth, noses, etc. The authors also introduce the penis and vagina as body parts. While this book is great at showing different bodies in a positive light, it does attribute penises to boys and vaginas to girls. It also incorrectly labels vulvas as vaginas.

### ***Elementary age***

Bergman, S. B. (2012). *The Adventures of Tulip, Birthday Wish Fairy*. Flamingo Rampant.

This picture book is written to help elementary-school-age kids learn about gender identity. When confronted with a child who is grappling with her identity as a transgirl, the Birthday Wish Fairy has to learn more so she can help, and the reader learns alongside the fairy.

Brown, K. B. & Brown, M. (1997). *What's the Big Secret? Talking About Sex with Girls and Boys*. Hachette Book Club.

This picture book provides a basic overview of anatomy and reproduction. It also provides some information about childbirth. The authors present information by comparing girls' and boys' bodies, so the book is limited to a binary gender representation. It discusses heterosexual sex as the only means of reproduction.

Dunham, K. & Bjorkman, S. (2017). *The Boy's Body Book*. Appleseed Press.

This chapter book provides introductory information on a wide range of topics including puberty, hygiene, friendships, home life, and risk behaviors. The information is very basic, best suited for eight- to ten-year-olds who have not been exposed to more advanced information. The sections on "dating and romance" is heteronormative.

Hall, M. (2015). *Red: A Crayon's Story*. HarperCollins.

This book tells the story of a mislabeled crayon that has a red label but can only color in blue. The crayon must go on an identity journey to discover themselves. This book is a great way to introduce gender identity development to grade-school-aged children.

Harris, R. H. & Emberley, M. (2014). *It's So Amazing! A Book About Eggs, Sperm, Birth, Babies, and Families*. Bee Productions.

This is a chapter book with comic-like illustrations that informs children about the reproductive process from conception up until the birth of a child, including fetus development. This is most appropriate for older elementary ages. Its counterpart for younger elementary children, *It's Not the Stork*, is discussed below. The more advanced concepts of birth control, abortion, abstinence, masturbation, and sexual orientation are briefly introduced. Sexual abuse, privacy, and seeking help are also briefly discussed. Anatomy is presented as gender binary and the terms "sex" and "gender" are incorrectly used interchangeably.

Harris, R. H. & Emberley, M. (2006). *It's Not the Stork! A Book About Girls, Boys, Babies, Bodies, Families, and Friends*. Bee Productions.

This is a chapter book with comic-like illustrations that informs early elementary children about the reproductive process and pregnancy. Adoption is discussed, along with diversity in family structures, including a brief mention of being raised by foster parents. Anatomy is presented as gender binary.

Hoeger, C. & Lilla, K. (2019). *Vaginas and Period 101: A Pop-Up Book*. Sex Ed Talk, LLC.

This gender-inclusive pop-up book is a fun way to educate young people on anatomy, menstruation, and menstrual product options. This book is for youth ages eight to twelve.

King, Z., King, K., & Rama, S. (2010). *I Said No! A Kid-to-Kid Guide to Keeping Private Parts Private*. Boulden Publishing.

This book is written from the perspective of a young child talking directly to the reader. The book introduces the concept of private parts and then talks children through a range of situations in which they can identify green flags that mean something is safe and red flags that might mean danger. It ends with a discussion guide for caregivers and an opportunity to work through an exercise with a caregiver. This book also addresses feelings of guilt and shame that may be associated with such situations. The authors describe private parts using gender binary language, calling private parts “what is under underwear” for boys and “under underwear or undershirts” for girls. Caregivers using this book should expand that concept to include the idea that entire bodies are private and should correctly label private parts.

Moore-Mallinos, J. & Fabrega, M. (2005). *Do You Have a Secret? Let's Talk About It*. Barron's.

This picture book explains the difference between fun secrets that make you happy and bad secrets that you should not keep. Examples of bad secrets include witnessing another child get bullied and touches that make them feel “yucky.” Children are encouraged to talk to trusted adults. The book presents rhetorical questions that caregivers can use to have their own conversations with children.

Schaefer, V. & Masse, J. (2012). *The Care and Keeping of You: The Body Book for Younger Girls*. American Girl.

This is a chapter book written for girls ages eight and up. This book is written in a conversational style, as though the narrator is talking directly with a child about different areas of their body. The book covers hygiene, puberty, menstruation, and healthy lifestyle issues. This book has been criticized for assuming that all young girls have self-esteem and body issues. For children who do not have those feelings, it might inadvertently introduce those concepts.

Silverberg, C. (2015). *Sex Is a Funny Word: A Book About Bodies, Feelings, and YOU*. Seven Stories Press.

Silverberg’s comic-book style introduction of sexuality through a diverse and inclusive cast of characters is designed to be age-appropriate and fun for children ages eight to 10. It is fast becoming a well-known and loved classic!

### ***Tweens and teenagers***

Corinna, H. (2016). *S.E.X.: The All-You-Need-to-Know Sexuality Guide to Get You Through Your Teens and Twenties* (2nd ed.). Da Capo Press.

While ostensibly for teens and twenty-somethings, this book has something new and engaging about sexuality to offer to almost everyone. Corinna owns and manages Scarleteen ([www.scarleteen.com](http://www.scarleteen.com)), which was the first, and remains the most interactive, website about sexuality designed for young people. Corinna has seen and answered it all, and she brings that wealth of knowledge and experience to this book.

Corinna, H. & Rotman, I. (2019). *Wait, What? A Comic Book Guide to Relationships, Bodies, and Growing Up*. Limerence Press.

This comic book is an easy read for youth and it is one of the only books that introduces anatomy and puberty using non-gender-binary language. It also addresses gender, attraction to others, and consent.

Gonzales, K. & Rayne, K. (2019). *Trans+: Love, Sex, Romance, and Being You*. Magination Press.

An all-inclusive, uncensored guide for teens who are transgender, nonbinary, gender-nonconforming, or gender-fluid. *Trans+* answers all your questions, easy and hard, about gender and covers mental health, physical health and reproduction, transitioning, relationships, sex, and life as a trans or nonbinary individual. It's full of essential information youth need—and want—to know and includes real-life stories from teens.

Harris, R. H. & Emberley, M. (2014). *It's Perfectly Normal: Changing Bodies, Growing Up, Sex, and Sexual Health*. Candlewick Press.

This is a chapter book designed for youth that covers a wide range of sexual health topics. Illustrations include different body parts and anatomy. Anatomy is presented as gender binary and the terms "sex" and "gender" are incorrectly used interchangeably. More advanced concepts are discussed in detail. These include birth control, abortion, adoption, abstinence, masturbation, and sexual orientation. Sexual abuse, online safety, and seeking help are also discussed.

Lang, J. (2018). *Consent. The New Rules of Sex Education: Every Teen's Guide to Healthy Sexual Relationships*. Althea Press.

This book assumes youth have a foundation of anatomy and the basics of reproduction. It would be most appropriate for an older youth who has a high reading level. The author, who is a medical doctor, uses youth-friendly language and tone to speak to the reader. She talks about dating relationships, consent, safe sex, and abusive relationships.

Natterson, C. & Masse, J. (2012). *The Care and Keeping of You 2: The Body Book for Older Girls*. American Girl.

This is a chapter book detailing physical changes in the body and hygiene. It provides an illustration on inserting tampons and provides information about menstruation. It does not discuss sex or masturbation, nor does it label the clitoris in a diagram of anatomy. This book would be best for younger adolescents or late-elementary-age adolescents.

Middleman, A. B. & Pfeifer, K. G. (2006). *Boy's Guide to Becoming a Teen*. American Medical Association.

This is a chapter book that provides information for adolescents. Topics include puberty, healthy life habits, hygiene, masturbation, feelings, relationships, and sex. Birth control and sexually transmitted infections are discussed.

Rayne, K. (2017). *GIRL: Love, Sex, Romance, and Being You*. Magination Press.

Written for all self-identified older teen girls, Dr. Rayne's book is written to be accessible, informative, and supportive of every individual's sexual development. It includes topics rarely covered in other resources, like ending relationships in healthy ways and a real and honest assessment of hook-ups. People of all ages have found new and useful information about sexuality in *GIRL*.

## Communication

Tatkin, S., & Hendrix, H. (2012). *Wired for love: How understanding your partner's brain and attachment style can help you defuse conflict and build a secure relationship*. Oakland, CA: New Harbinger Publications.

Understanding a person's attachment style gives so much insight into the ways that they need to be communicated with. Tatkin and Hendrix break down this psychological framework and use it to provide insight and support for people communicating in romantic and sexual relationships.

## Gender Identity

Brill, S. A., & Kenney, L. (2016). *The transgender teen: A handbook for parents and professionals supporting transgender and non-binary teens*. Jersey City, NJ: Cleis Press.

Brill and Kenney share great insights about how to talk with teenagers who identify as transgender. Mental health practitioners will find resources, explanations, and useful information on talking about gender.

Ehrensaft, D. (2016). *The gender creative child: Pathways for nurturing and supporting children who live outside gender boxes*. New York: The Experiment.

In her follow-up to her widely popular first book, *Gender Born, Gender Made*, Ehrensaft delves deeper into the world of gender identity and expression development in children. Mental health practitioners will find updated research and resources on gender identity, gender expression, and supporting gender creative children.

Gender Spectrum [Website]. Author. <https://www.genderspectrum.org/>

Gender Spectrum is dedicated to creating gender sensitive and inclusive environments for all children and teenagers. Mental health practitioners will find resources such as trainings, conference information, books and media, faith, medical, and legal, just to name a few. Gender Spectrum also offers an online community for teens, parents, and professionals.

Gottlieb, I. (2019). *Seeing Gender: An Illustrated Guide to Identity and Expression*. Chronicle Books.

This easy-to-read book provides a in-depth understanding of gender identity along with a look at how coexisting identities relate to gender. Gottlieb also includes relatable stories of people's experiences with gender identity. Lastly, this book offers tools for readers to use when exploring their own gender identity.

Testa, R. J., Coolhart, D., & Peta, J. (2016). *The Gender Quest Workbook: A Guide for Teens and Young Adults Exploring Gender Identity*. New Harbinger Publications.

The *Gender Quest Workbook* is a great resource to use with young people who are beginning to develop and explore their identity. This introductory book is full of activities to help the youth begin their journey of self-discovery.

Transgender Law Center [Website]. <https://transgenderlawcenter.org/>

The Transgender Law Center (TLC) is a transgender-led organization with legal expertise advocating for the self-determination of all people. Mental health practitioners will find resources such as various TLC programs and policy information on youth, employment, identity documentation, family law, and more. TLC can keep you and your clients up to date on the political climate and other much needed information.

WPATH [Website]. World Professional Association for Transgender Health. <http://www.wpath.org/>

The World Professional Association for Transgender Health (WPATH) is one of the world's largest transgender health organizations. WPATH is dedicated to providing and engaging in the most up-to-date medical and academic research. Mental health practitioners will find many resources including a standards of care for medical and mental health practitioners who work with transgender and nonbinary clients. WPATH also offers a certificate program to mental health and medical practitioners.

## General

Roach, M. (2008). *Bonk: The curious coupling of science and sex*. New York, NY: Norton.

In an incredible feat of curation, Roach pulled together research on sex and sexuality and made it enlightening, funny, useful, and above all, readable in the way that only she can. With chapter titles such as “Dating the Penis-Camera,” “The Immaculate Orgasm,” and “Persons Studied in Pairs,” this book is a top-choice read for anyone interested in sex (which, let’s be honest, is almost everyone).

## History of Sexuality

Barker, M., & Scheele, J. (2016). *Queer: A graphic history*. London, England: Icon Books.

Queer theory is deeply entrenched in a convoluted historical trajectory, which this graphic book outlines in clarifying detail. It is designed for people who are questioning their own identity, who want to work with and provide support for queer people, or who are confused by the emerging language around LGBTQ+ identities. It’s accessible and fun—something that’s not easy to say about most books trying to explain queer theory.

Berkowitz, E. (2013). *Sex and punishment: Four thousand years of judging desire*. Berkeley, CA: Counterpoint Press.

The history of laws restricting sex and sexuality is long and varied. Berkowitz provides context for our current restrictions by going back centuries and tracing the entire path of Western sex law. Told as a series of stories, rather than being a dry law textbook, this book is interesting and informative.

Blank, H. (2012). *Straight: The surprisingly short history of heterosexuality*. Boston, MA: Beacon Press.

In addition to a delightful accounting of the differences between sex, gender, and sexual orientation, Blank provides a fascinating historical account of how we came to understand these constructs through a fairly narrow linguistic lens. As we are moving away from that lens on a cultural level, it is useful to know how we got there in the first place.

## Intersectionality

Berg, R. (2016). *No House to Call My Home: Love, Family, and Other Transgressions*. Nation Books.

Berg dutifully shares the stories of eight queer youth in the foster care system in order to bring to light the way homelessness uniquely affects LGBTQ+ people. Playing the role of friend, sex educator, brother, parent, social worker, and advocate, Berg shows us how many different faces trauma can take. Anyone in contact with homeless youth should read this book.

Kaufman, M. & Silverberg, C. (2007). *The Ultimate Guide to Sex and Disability: For All of Us Who Live with Disability, Chronic Pain, and Illness*. Cleis Press.

People with physical difficulties are rarely included in the dialogue about sexuality, even when that dialogue says that all people are sexual. Kaufman and Silverberg provide voice and support for the people who have been cut out of this dialogue. Including people with a wide range of disabilities, ages, genders, and sexual orientations, this book provides encouragement, support, and concrete tips.

McRuer, R. (2012). *Sex and Disability*. Duke University Press.

Actively challenging the concept of what disability is, McRuer's series of essays forces a direct connection between queerness, sexuality, and disability. Examining ableist and heteronormative ideas of desire, sexuality, and queer theory, Sex and Disability combines multiple writing styles to evoke an understanding of everyone's queerness and impending addition to the disability community. See also Crip Theory by McRuer.

Nasserzadeh, S., & Azarmina, P. (2017). *Sexuality education Wheel of Context: A guide for sexuality educators, advocates and researchers*. (n.p.): Authors.

Nasserzadeh and Azarmina created a framework called the "Wheel of Context" that provides a structure for considering cultural differences and how to work professionally across them,

with examples and specifics designed to resonate with educators. Nasserzadeh is an acclaimed sexuality educator and counselor who created the framework so that it is useful in both education and counseling settings.

## Kink

Donaghue, C. (2015). *Sex outside the lines: Authentic sexuality in a sexually dysfunctional culture*. Dallas, TX: BenBella Books.

Donaghue explores sexuality in our culture and how it has impacted us as sexual beings, delving into what kink “is” in a culture like the United States. Mental health practitioners will find a fresh, new voice in this work for sexual freedom and kink.

Ortmann, D. M., & Sprott, R. A. (2013). *Sexual outsiders: Understanding BDSM sexualities and communities*. Lanham, MD: Rowman & Littlefield.

Ortmann and Sprott, both mental health practitioners, offer a detailed and introductory look into the often misunderstood community of BDSM and kink. This is a great book for all mental health professionals who wish to expand their knowledge on kink and kink communities.

## Parenting

Bergman, S. B. (2013). *Blood, Marriage, Wine, and Glitter*. Arsenal Pulp Press.

Bear tenderly shares the difficulties and unique beauty of family. The nuclear family is dead in this book detailing how a community of queer people, artists, sperm-donors, polyamorous loves, ex-loves, and two trans dads end up being the perfect group to raise the modern family. An emotional and giggle-worthy read suitable to all audiences.

Davis, D. (2004). *You look too young to be a mom: Teen mothers speak out on love, learning, and success*. New York, NY: Perigree.

Teen mothers are often dismissed by society, denigrated for being irresponsible, and assumed to be bad parents. This book, while somewhat dated, provides a very different perspective. It includes personal essays from teen parents, both current and past, describing the positive impacts adolescent parenting is having and has had on their lives. This book is a huge winner for teenagers who have internalized the cultural negativity around teen parents but who are stepping into the parenting role.

Rayne, K. (2015). *Breaking the hush factor: Ten rules for talking with teenagers about sex*. Austin, TX: Impetus Books.

Dr. Rayne introduces ten rules for adults who talk with teenagers about sexuality. The rules are broken into three groups: “Preparing Yourself,” “When You & Your Teen Talk,” and “The Voice Inside.” The premise of these steps is to guide parents and other adults toward openness in their

conversations, encouraging them to learn how to really listen to their teenagers' growing sense of sexual self with curiosity and encouragement. The steps can apply to other difficult topics in addition to sexuality.

Warner, J. (2005). *Perfect madness: Motherhood in the age of anxiety*. New York, NY: Riverhead Books.

Many women find the role of mother to be a difficult one, with incredibly high expectations and very little chance to see what is happening in other mothers' homes outside of highly curated social media presences. This book provides a critical cultural analysis of what got mothers to these cultural expectations and how mothers can survive it.

## Polyamory

Easton, D. (2009). *The ethical slut: A practical guide to polyamory, open relationships & other adventures* (2nd ed.). Berkeley, CA: Celestial Arts.

Understanding the ways people engage in sexual and/or romantic relationships that include more than two people is difficult for many people. This classic book has come to be accepted as a must-read for couples who are considering a step toward openness or polyamory, and it can also support mental health practitioners who are coming to understand this dynamic.

Pincus, T. & Hiles, R. (2017). *It's Called Polyamory*. Thorntree Press, LLC.

This book provides readers with the tools needed to inform partners, family, friends, and work colleagues about being in a polyamorous relationship. In addition, this guide includes a list of helpful resources to further readers' knowledge of the topic.

Taormino, T. (2008). *Opening up: A guide to creating and sustaining open relationships*. San Francisco, CA: Cleis Press.

Taormino is an award-winning columnist and sex educator known for her work in kink, porn, and relationships. *Opening Up* is an easy-to-understand guide to creating an open relationship. This is also a great resource for mental health practitioners interested in learning about polyamory and open relationships.

## Religion

Conley, G. (2018). *Boy Erased: A Memoir of Identity, Faith, and Family*. Riverhead Books.

Conley writes a powerful memoir about fundamentalist conversion "therapy" he experienced after being sexually assaulted in college. An emotional rollercoaster that was made into a movie, this book gives insight to those unaware of the history and continuing practice of abuse disguised as well-intended therapy that is actively being outlawed across the country.

Ott, K. (2013). *Sex + faith: Talking with your child from birth to adolescence*. Louisville, KY: Westminster John Knox Press.

Two of the most difficult topics parents struggle with are sexuality and religion. Combining them can make for an even more difficult time! Ott provides a path forward when grappling with the connections and relationships between the two, including an age-by-age presentation of how to have the conversation.

Religious Institute [Website]. <http://religiousinstitute.org/>

A self-described “multifaith organization dedicated to advocating for sexual, gender, and reproductive health, education, and justice in faith communities and society,” the Religious Institute sits at one of the most combustive ideological intersections in our country. They provide resources, guidance, and vision for how religious institutions can provide sexuality education and be inclusive in their religious practice.

## Reproductive Justice

Ross, L. & Solinger, R. (2017). *Reproductive Justice: An Introduction*. University of California Press.

A more up-to-the minute presentation of the reproductive justice movement could not be possible. Centering the dialogue on individual experience, intersectionality, and what we need to do moving forward, Ross and Solinger provide an introduction to a field of work and study that many people have inaccurately understood as merely about abortion. Providers will find this information useful and applicable as they work with clients who grapple with their own agency and identity as it relates to reproduction and reproductive health.

Ross, L. J., Roberts, L., & Derkas, E. (2017). *Radical Reproductive Justice: Foundation, Theory, Practice, Critique*. Feminist Press at the City University of New York.

A must-read for an in-depth understanding of the reproductive justice movement. This book explains the history of the SisterSong Women of Color Reproductive Justice Collective in relation to the movement and how reproductive justice is practiced today.

## Sexual Activity

Barker, M., & Hancock, J. (2017). *Enjoy sex (how, when and if you want to): A practical and inclusive guide*. London, England: Icon Books.

Barker and Hancock center their discussion of sex and sexuality on the reader. Because they understand the ways in which sexual activities are so completely personal, they shift the definition of “normal” sexuality to the specific experiences of each person.

Chase, E. (2017). *Curvy girl sex: 101 body-positive positions to empower your sex life*. Beverly, MA: Fair Winds Press.

The majority of publications about sexual positions and other details of sexual how-to are not inclusive of the wide range of body types that exist in the real world. Chase has brought this history to a crashing end. From basic to advanced and inclusive of all kinds of sexual preferences, many people of size and their partners will find these tips and tricks to be exactly what they have been searching for.

Comella, L. (2017). *Vibrator Nation: How Feminist Sex-Toy Stores Changed the Business of Pleasure*. Duke University Press.

An enjoyable read about the history of feminist brick-and-mortar sex-toy stores. This book details the history of vibrators in America and the education received by countless patrons to the first stores before the advance of the internet and Amazon. A great read for providers and youth interested in how feminist sex-toy sales advanced the cause and access to pleasure.

Cornog, M. (2003). *The BIG book of masturbation: From angst to zeal*. San Francisco, CA: Down There Press.

Examples of how people masturbate are merely one part of this substantial book. Other masturbation-related topics are examined through historical, evolutionary, philosophy, literature, and even sex therapy lenses. The information can support youth in finding activities that their bodies and brains enjoy.

Friedman, J. (2011). *What you really really want: The smart girl's shame-free guide to sex and safety*. New York, NY: Seal Press.

This book provides education, information, and a substantial opportunity for self-reflection. Filled with exercises for the reader to consider their own sexuality, with a focus on what they want sexually for themselves and their relationships, this guide can be particularly useful for women who are ready to learn more about their sexual selves.

Komisaruk, B. R., Whipple, B., Nasserzadeh, S., & Beyer-Flores, C. (2010). *The orgasm answer guide*. Baltimore, MD: Johns Hopkins University Press.

This orgasm guide is written in a question-and-answer format by some of the world's leading experts on the topics. The authors include researchers, neuroscientists, and sex therapists, so the answers are well-rounded and useful both in and out of clinical settings. If you find yourself unsure about how to provide answers to specific orgasm-related questions, this book will provide you with both a general framework and many specific examples.

Moen, E. & Nolan, M. (2016). *Oh Joy Sex Toy!*. Erika Moen Comics & Illustration, LLC, Periscope Studio.

The first in a delightful series of educational comic books on sex toys, *Oh Joy Sex Toy!* allows people of all ages to learn about pleasure, positioning, lubrication, and sex toys they may be

interested in through inviting illustrations and a joyful color palette. Moen and Nolan have created a wonderful collection of comics to support learning about hundreds of sexual health toys and pleasure-making objects.

Moon, A. (2015). *Girl sex 101*. Nanaimo, BC, Canada: Lunatic Ink.

Clocking in at 388 pages, and including the most specific range of information about all things related to having sex with self-identified girls, Moon's book was called "an invaluable and necessary resource" by the *Huffington Post*, and that is entirely accurate. From anatomy to pleasure and everything in between, girls and people who want to be sexual with girls will find this book incredibly eye-opening.

Morin, J. (2010). *Anal pleasure and health: A guide for men, women and couples*. Gardena, CA: Down There Press.

Anal pleasure is often misunderstood. When people try to include anal play and penetration in their sexual repertoire without fully understanding how to go about it safely, they can hurt themselves or their partners and be turned off from anal pleasure altogether. This book includes a detailed how-to to ensure that doesn't happen.

Nagoski, E. (2015). *Come as you are: The surprising new science that will transform your sex life*. New York, NY: Simon & Schuster.

As described in the title, this book covers the recent research about the anatomy and physiology of sexuality. With a focus on women's sexuality, the book investigates the ways in which each person's sexuality is unique and the importance of understanding sexuality in context. In a readable, accessible format, Nagoski's book is enlightening, applicable, and research-based.

## Sexual Consent

Friedman, J., & Valenti, J. (2008). *Yes means yes!: Visions of female sexual power and a world without rape*. Berkeley, CA: Seal Press.

This book became an immediate classic and may be considered the first in Friedman's trilogy (followed by *What You Really, Really Want* and *Unscrewed*). Setting the stage with a series of essays about consent that go deeper and provide a more holistic view of the issue than anything that came before, Friedman, with Valenti, offers a vision of what might be possible if consent were not routinely reduced to a simplistic concept of "no means no."

Harding, K. (2015). *Asking for it: The alarming rise of rape culture—and what we can do about it*. Boston, MA: Da Capo Press.

With the advent of #metoo in 2017, there was a sudden increase in the general awareness and understanding of rape culture. If you or a youth aren't sure what rape culture is, where it came from, how to think about it, or what to do next, Harding has you covered.

## Sexual Health

Centers for Disease Control and Prevention. (n.d.-a). Sexual health. Retrieved from <https://www.cdc.gov/sexualhealth/Default.html>

The concept of safer sex is complex and many-pronged. The Centers for Disease Control and Prevention provides current, medically and psychologically studied concepts that are critical to sexual decision-making.

Centers for Disease Control and Prevention. (n.d.-b). Sexually transmitted diseases (STDs). Retrieved from <https://www.cdc.gov/std/default.htm>

The Centers for Disease Control and Prevention always has the most up-to-date medical information, treatment options, and statistics about STIs. Maintaining awareness of any issues, particularly focusing on the area your clients live in, is useful in order to support them and their sexual decision-making.

Planned Parenthood Federation of America. (n.d.). All about birth control methods. Retrieved from <https://www.plannedparenthood.org/learn/birth-control>

Planned Parenthood's information about contraception is always accessible, medically accurate, up-to-date, and useful.

Wylie, K. R. (2015). *ABC of sexual health* (3rd ed.). West Ussex, United Kingdom: John Wiley.

In this concise book, Wylie, former president of the World Association of Sexual Health, covers a wide range of information related to sexual health, including medication, dysfunction, psychosexual development, and more.

## Sexual Orientation

Decker, J. S. (2014). *The invisible orientation: An introduction to asexuality*. New York, NY: Carrel Books.

Asexuality is one of the areas of sexual orientation where we are growing our learning and understanding the most, and this book provides a primer for anyone who is unsure what this term means. Including a thoughtful discussion of what it feels like to be asexual, this book is useful for practitioners working with asexual clients, anyone who knows and loves someone who is asexual, and anyone who is themselves asexual.

GLAAD [Website]. <https://www.glaad.org/>

GLAAD is a force in media advocacy. GLAAD attempts to change the media "script" to elevate cultural dialogue and increase acceptance of LGBTQ people. Mental health practitioners will find publications and GLAAD programs such as youth engagement, grants, and global initiatives.

Langford, P. (2020). *The Pride Guide: A Guide to Sexual and Social Health For LGBTQ Youth*. Rowman & Littlefield Publishers.

Langford aims to provide youth in the LGBTQ+ community with a comprehensive guide to sexuality education. This book covers topics related to puberty, coming out, dating, sex, and personal safety. Langford also includes two chapters discussing identity and expression for youth on the spectrum. This book is for youth ages 14–17 and the adults in their life who would like to educate themselves.

PFLAG [Website]. [www.pflag.org/](http://www.pflag.org/)

PFLAG was created in 1972 by a mother of a gay son who was hoping to influence policy change. PFLAG is now one of the largest family support networks in the country. Providers will find advocacy work, policy information, and chapter listings for local support groups.

## Sexual Rights

Friedman, J. (2017). *Unscrewed: Women, sex, power, and how to stop letting the system screw us all*. New York, NY: Seal Press.

In this riveting new book that picks apart the cultural erosion of women's rights, Friedman investigates where things have gone wrong and potential solutions to put them right. From money to media to maleness, Friedman delves deep and finds unique paths forward.

Levine, J. (2002). *Harmful to minors: The perils of protecting children from sex*. New York, NY: Thunder's Mouth Press.

While older, this book stands the test of time. It was the winner of the 2002 Los Angeles Times Book Prize, and for good reason. Harmful to Minors was written to address the moral panic around children's understanding of sex and sexuality that causes far more harm than it prevents. Levine's perspective can be particularly useful for parents or other adults who are resistant to young people learning information about sexuality that they have a demonstrated need for.

## Sexually Explicit Media

Klein, M. (2016). *His porn, her pain: Confronting America's PornPanic with honest talk about sex*. Santa Barbara, CA: Praeger.

Klein is one of the leading voices talking about First Amendment rights as they apply to sexuality broadly and sexually explicit media specifically. This book is designed to be easy to read and accessible by the general public, providing a framework for talking about something that remains one of the most contentious relational issues in the United States today.

Ley, D. J. (2014). *The myth of sex addiction*. London, United Kingdom: Rowman & Littlefield.

Sex addiction has long been assumed to be an element of some people's sexuality. Ley questions the research that leads to this framework, showing it to be primarily moral or cultural judgments rather than real science. Instead, Ley proposes a new way of thinking about out-of-control sexual behavior that is rooted in a society that either condones or ignores it as a critical element of rape culture.

## Social Media

Boyd, D. (2014). *It's Complicated: The Social Lives of Networked Teens*. New Haven, CT: Yale University Press.

Young people are often portrayed as obsessed with digital technology and social media. Adults roll their eyes and talk about how we need to get kids off their phones. But is that really true? Boyd breaks the stereotypes and points to the real issues with youth and digital technology in ways that are respectful and supportive of adolescent culture. This book is useful for both professionals and parents who are grappling with understanding and working with the generational digital divide.

Ogas, O. & Gaddam, S. (2011). *A Billion Wicked Thoughts: What the Internet Tells Us About Sexual Relationships*. New York, NY: Plume.

While 2011 was generations ago in digital media time, the statistics and associated analysis that Ogas and Gaddam bring here are still relevant. They offer a new version of Kinsey's research from the 1950s, expanded to a global scale.

## Trauma

Perry, B. & Szalavitz, M. (2017). *The Boy Who Was Raised as a Dog*. Basic Books.

This classic book on child trauma details what happens when children experience stress and trauma. Dr. Perry uses clinical cases to explain neuroscience in a clear and understandable way to non-scientists.

Schladale, J. (2013). *A Trauma-Informed Approach for Adolescent Sexuality*. Resources for Resolving Violence, Inc.

This report is a must-read for anyone working with youth who have experienced trauma. It is the first guide to specifically address sexuality and provides easily understandable guidance for caregivers from a holistic perspective.

Van der Kolk, B. (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin Books.

Trauma is a complex topic, but Dr. van der Kolk provides an easily understandable explanation of how trauma impacts physical and psychological well-being. This book will help caregivers understand why healing takes time and why healing does not occur on a linear path.



## About the Authors



Karen Rayne, PhD, CSE

Dr. Karen Rayne is the Executive Director of UN|HUSHED, an organization dedicated to creating and implementing the highest quality sexuality education curricula possible. She is also an Assistant Professor of Instruction in the Educational Psychology Department at the University of Texas. She is a past editor and sits on the board of the *American Journal of Sexuality Education*, is the author of books like *GIRL: Love, Sex, Romance, and Being You*, *TRANS+: Love, Sex, Romance, and Being You*, and *Breaking the Hush Factor: Ten Rules for Talking with Teenagers about Sex* as well as a wide range of curricula and other professional resources. She is frequently sought after to share her expertise through training professionals, consulting with schools, writing articles, giving radio and print interviews, and speaking with parents. Dr. Rayne lives in the hill country outside Austin, Texas, with her wife, three children, and two dogs.



Amber Borcyk, MSSW, LCSWA

While attaining their master's degree in social work, Amber Borcyk knew they wanted to cultivate a career in sexuality education. During this time, Amber had the exciting opportunity to collaborate with Dr. Karen Rayne and Dr. Monica Faulkner on this handbook. Amber also became trained in UN|HUSHED's sexuality education curricula for middle and high school students. Since graduating in 2019, Amber has become a sex-positive therapist who provides sexuality education services to people of all ages. Moving forward, Amber will continue creating resources aimed at deconstructing shame about sexuality and empowering people to redefine what sexuality and pleasure means to them. Outside of work hours, Amber enjoys exploring North Carolina's hiking trails with their partner and pup.



### Monica Faulkner, PhD, LMSW

Monica Faulkner is a social worker who now does research on programs and practices in child welfare and foster care. She is passionate about reforming the foster care system so that it provides services to families rather than divides them. As a social worker, Monica has worked as an advocate for survivors of domestic violence and sexual assault and as a case manager for children in foster care. She is now a Research Associate Professor at the [Steve Hicks School of Social Work at the University of Texas at Austin](#) and the Director and Co-Founder of the [Texas Institute for Child & Family Wellbeing](#). She holds undergraduate degrees in government and social work from the University of Texas at Austin and a master's in social work from the University of Houston. She received her PhD in social work from the University of Texas at Austin in 2010. She is the Foster Care Liaison for UT Austin where she spends her spare time checking in with foster alumni on campus. She is also a board member for Healthy Teen Network and Education Reach for Texans. Monica lives in Round Rock, Texas, with her two daughters, husband, dog, and two cats. She loves reading historical fiction when she gets a moment of peace.