

An Introduction to  
*Sexuality Education:*  
A Handbook for  
Mental Health Practitioners

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

*How I Got Into Sex... Ed*

*Breaking the Hush Factor: Ten Rules for Talking with Teenagers about Sex*

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*25 Great Lesson Plans about Sexual Orientation*

*Trans+: Love, Sex, Romance, and Being You*

*Orientation: Teaching about Identity, Attraction, and Behavior*

# **An Introduction to Sexuality Education: A Handbook for Mental Health Practitioners**

By Karen Rayne, PhD, CSE and Ryan Dillon, LPC

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- the observant, dedicated mental health practitioners around the world who teach about sexuality.

All of you have played a critical role in bringing *An Introduction to Sexuality Education: A Handbook for Mental Health Practitioners* into being.

# A Letter from the Authors

**Dear Reader,**

Welcome to *An Introduction to Sexuality Education: A Handbook for Mental Health Practitioners!* This handbook will introduce you to the world of sexuality and the role of sexuality educator by providing the basic knowledge and skills needed to discuss sex and sexuality in a therapeutic environment.

## About the Collaboration

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

Karen brings many years 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.

Ryan brings a keen mental health practitioner perspective. In private practice, Ryan focuses primarily on working with youth and young adults along the gender and sexuality spectrum. Ryan specializes in working with this population to develop healthy identities and writes primarily about how to incorporate conversations about sex and sexuality into a clinical healthcare setting.

Because of the different lenses that Karen and Ryan bring, they each authored specific sections of this handbook. 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, couples', group, and psychoeducational therapeutic environments. All the resources, including handouts, can be tailored to work with clients 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 Mental Health Practitioners* and make it your own. As all mental health practitioners know, every client is different, and 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 into sessions with your clients depends on the specifics of each individual. 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 Boards

If you are working with minors, please consult your state mental health board for guidelines on working with, speaking to, and reporting procedures concerning minors. Depending on the age of consent laws in your state, a parent and/or guardian may need to be notified concerning the conversation topic of sex and sexuality. We do not discuss any local, state, national, or international regulations in this handbook because they are too variable and shift too frequently for this to remain a reliable resource.

Many thanks to each of you for your work. Bringing information and introspection about sexuality to people in need of it helps make the world a kinder, more inclusive, more compassionate place for all of us.

Sincerely,



Karen Rayne, PhD



Ryan Dillon, LPC

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## Introduction

The role of mental health practitioner takes many forms. One of those can be as a sexuality educator. Colleagues often ask us *why is the role of sexuality educator important for mental health practitioners?* and what is the *difference between sex therapy and sexuality education?*

In the field of mental health, we mainly hear and are taught about sex and sexuality as “problems” to be solved. We are asked to address sexual health problems, women’s sexual problems, men’s sexual problems, couples’ sexual problems, compulsive sexual behavior ... and the list goes on. While these topics are important and need to be addressed, they aren’t the only sexuality-related topics clients need us to talk about.

It is important for all mental health practitioners to have at least a basic understanding of sexuality to better help their clients. Whether you are working with a teen or an adult, everyone has feelings, thoughts, and experiences about sexuality, so the topic is bound to come up. Being prepared for the complexities of sexuality is key to being confident and effective. Many times, it is our role to educate clients who have common misconceptions or misinformation about sex and sexuality. Topics can include anatomy and physiology, body image, gender identity, healthy communication, birth and pregnancy, sexual orientation, safer sex, STIs, and much more.

### **Sex Therapy, Sex Education, and Sexuality Education**

The word *sexuality* is broad and encompassing. In this handbook we often use *sexuality* rather than *sex* because the latter is often understood to mean only a specific set of sex acts. *Sexuality*, however, usually includes a person’s entire being and everything a community has to say about the intimate, relational, and cultural aspects of sexuality. However, the phrases *sex therapy*, *sex education*, and *sexuality education* push back against the way that sex and sexuality are typically used.

Sex therapy provides and addresses sex and sexuality through a therapeutic lens. Sex education and sexuality education provide knowledge and information. All three of these professional endeavors, when at their most effective, are about sexuality in a broad sense rather than sex in a narrow sense. In this handbook, we use the words and phrases that are most common (*sex therapy and sexuality educator*).

Sex therapists are mental health practitioners who specialize in therapy with clients concerning sex, sexuality, and sexuality-related topics. Many, although not all, sex therapists have specific training about sex therapy or have attended continuing education on sexuality-related topics and issues. These professionals have increased skills at addressing sexual topics from a therapeutic lens to assist their clients. It is important to remember that all therapists need the basic skills that this handbook is designed to provide!

Just as many mental health practitioners who are not specifically trained as sex therapists discuss sexuality with their clients, many teachers, educators, facilitators, and other people who are not

trained as sexuality educators nevertheless teach about sex. This includes nurses, coaches, history teachers, therapists, counselors, parents, and sometimes even the random person who ends up at the right place at the right time (or the wrong time!).

For mental health practitioners, bringing the education framework into the clinical setting requires staying up to date with sexual information and being impartial despite potential personal biases. Both of these things require time and attention, and both are fully accomplishable without being an expert. Rather, the key is to refrain from judgment, to be open to your own and your clients' questions, and to use resources and experts extensively.

## What's Included in the Handbook?

This handbook includes the following sections:

- **An Introduction**—You're already here!
- **Self-Analysis for Mental Health Practitioners**—It is important for mental health practitioners to constantly and consistently analyze themselves and their beliefs. In this section, Ryan provides one simple and easy way to practice self-analysis.
- **All About Sexuality**—Karen takes the reins in this section to outline a few of the many potential topics about sexuality. Covering topics from accessing sexual health care to terminating a pregnancy, this is a great place to continue your learning about sexuality.
- **Handouts**—Engaging handouts make content easier to learn. More than 15 sexuality handouts designed or repurposed for use in a mental health setting are included. Ryan provides a guide with suggested ways to use each handout in a clinical setting.
- **References**—This gives credit to our sources.
- **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 Karen's and Ryan's favorite resources, including books, articles, websites, and organizations, so you can continue your research into the world of sexuality.

## Trauma, a Top-Level Concern

(This subsection adapted from *UN|HUSHED: The Middle School Curriculum* (Facilitator Guide, p. 29) by K. Rayne and J. Smarr, 2019, Austin, TX: UN|HUSHED. Copyright 2019 by UN|HUSHED. Adapted with permission.)

We can't always assess a client's trauma history in every aspect of their lives. It is important to know that many people have traumatic experiences concerning sex and sexuality. As a mental health practitioner, you may or may not be the first person your client discloses a sexually traumatic experience to. However,

being a mental health practitioner comes with the need to respond to clients who have experienced or are experiencing sexual trauma. Therefore, it is always important to provide trauma-informed care as it relates to sex and sexuality.

Mental health practitioners are well aware of what trauma is and of the lasting effects it can have on individuals. However, what constitutes a traumatic experience in the world of sexuality may not always be evident, because different people experience and internalize trauma in different ways. Here are a few examples of experiences around sex and sexuality that some people may find traumatic:

- being adopted;
- being bullied about sexuality;
- being pregnant;
- coming out as LGBTQ+;
- giving birth;
- surviving incest;
- surviving rape;
- surviving religious indoctrination;
- surviving sexual harassment;
- surviving sexual assault;
- surviving rape;
- surviving sex trafficking; and
- viewing pornography.

Some people do not find all these experiences traumatic, while others do. As mental health practitioners it is important to keep in mind that you do not know all the experiences of your clients, even if you have extensive knowledge concerning their histories. And even when you are aware of their sexual experiences, you may not know whether they experienced them as traumatic or not.

You must be aware of your language, questions, and activities and how they might raise negative feelings and reactions in your clients. The exact words that a person uses can change the meaning in ways that seem subtle to the speaker but are potentially triggering to the listener.

For example, take these two statements:

- “If you were raped by a partner, that can be hard to recover from.”
- “If a person rapes their partner, it can be difficult for the survivor to recover.”

The first example puts the listener in the position of being raped and frames it in such a way that they were an active participant (being raped), even though they were not the perpetrator of the sexual assault. This can be both emotionally and mentally triggering for a client who has been through this experience.

The second example puts emotional distance between the listener and the person being raped by removing “you” from the sentence. It also affirms that the action clearly belongs to the person doing the sexual assault. This is less likely to become emotionally and mentally triggering because it takes a step back from the personal and becomes an objective statement about another person.

It is impossible to guarantee that nothing you say will ever trigger a client. Someone might be triggered, for example, by the sound of a train whistle or a picture of a high school locker room because they experienced trauma with those sensory inputs as backdrops. Some people are not even fully aware of their own triggers. With so many unknown potential triggers, it is critical to pay attention to your clients’ reactions so that you are aware of an emotional shift if it happens. However, being conscious of and knowledgeable about the language you use is likely to lessen the possibility of triggering a client.

Remember that sexual trauma and the associated triggers can be effectively addressed in a mental health setting. Look to the resource list at the end of this handbook for more information on this specific topic.

## Self-Analysis for Mental Health Practitioners

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. Mental health practitioners are not immune to this barrage of misinformation. What is unique about mental health practitioners is that they are often perceived to be safe authorities to ask questions of about sexuality.

A mental health practitioner will never agree with 100% of their clients 100% of the time. It is our job to have the ability to look past our own biases, beliefs, and issues to support clients in the most knowledgeable and healthy way possible. One way to make sure that we can provide this service to our clients is to *constantly* and *consistently* challenge our own thoughts and feelings, and never to become complacent. We are always growing as people, which means we should always be growing as mental health practitioners. Our clients deserve to have the best therapeutic services possible, and we must grow and analyze ourselves to be able to provide this.

Some mental health practitioners are never uncomfortable with sexual questions—or the answers. Most experience some discomfort over time. Often the discomfort is fueled by societal structures and the practitioner's personal biases surrounding the topic. For sex therapists or other professionals who specialize in sexuality, a training called a *Sexual Attitude Reassessment* (SAR) was designed to specifically push those boundaries in a safe space so that these professionals can handle themselves effectively in clinical spaces. However, attending a full SAR is outside the reach of many mental health practitioners, and so other means of self-analysis surrounding sex and sexuality is critical.

As you read further into this section, please remember what the American Counseling Association (ACA) says about personal values. According to the *ACA Code of Ethics*, Section A.4.b. "Personal Values" (2014):

*Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature.*

Analyzing one's own personal biases is not an inherently easy task. It should begin with asking oneself pointed questions concerning sexual topics, like those listed below. You can go even further. If a client brings up a topic or you watch or read a story that makes you uncomfortable, then dive into that discomfort and explore it.

### Time to Challenge Yourself

This is a short, simple activity to support you in thinking through what might be your own biases and areas of contention around sexuality. Read each of the questions and statements below, then sit with your reactions and process your thoughts and feelings. Take a moment after each question

or statement to process your reaction and consider what you would want your verbal and nonverbal answers and responses to be. Remember, a client of any age could bring up any of these at any time in session.

- “Transgender people are confused and need to be fixed.”
- “It’s unlikely for someone to know what their sexual orientation is before they are even in high school.”
- “There are only two genders, man and woman.”
- “What messages did I receive about LGBTQ+ people as I was growing up? Have experiences in my adult life changed my opinions?”
- “How would I feel if a close family member told me that they were gay, lesbian, bisexual, transgender, or queer? Would I respond differently if it were a colleague at work?”
- “Young teenagers may think that they are in love, but people that young don’t fall in love for real.”
- “People in open or polyamorous relationships should not be able to have children.”
- “Open or polyamorous marriages are not physically or emotionally healthy and are destined to fail.”
- “BDSM (any of the forms of bondage and discipline, dominance and submission, and sadism and masochism) is unhealthy and isn’t a lifestyle people should want.”
- “Spanking for sexual pleasure is a form of abuse and should be reported.”
- “It’s a problem for people of different religions to date each other.”
- “It is a problem for people of different ethnicities to date each other.”
- “It’s okay to talk someone into having sex as long as they agree to it in the end.”
- “Someone with an intellectual disability cannot consent to sex.”
- “A man is in charge of his family.”
- “Older adults living in nursing homes probably don’t have sex.”

How did the above statements and questions make you feel? If a particular statement made you uncomfortable or challenged a belief, what would you do if the topic came up in the therapy room?

## Red or Green

Many of the above questions and statements are asked in an activity included in *UN/HUSHED: The Middle School Curriculum*. During the activity there are two pieces of paper on the wall, red and green. After each question or statement, the participants must make a choice to either agree (green) or disagree (red), and stand by the corresponding piece of paper on the wall. After the participants decide whether to agree or disagree, the facilitators ask for volunteers from each side to say why they made their choices. This often leads to lively dialogue about values and perceptions. Making this an “agree” or “disagree” activity, with no middle ground, forces the participants to think critically and process their thoughts and feelings. During the discussion portion some participants change their minds after hearing other participants’ perspectives.

Read over the statements again and imagine yourself participating in the activity. Which statements make it hardest for you to know where you stand? Which ones make you most want to create a middle ground? Which ones do you feel the most certain that there is a “right” answer for?

This process isn’t actually to force you to pick a side or to think in black and white. The purpose is for you to deeply consider each statement and question—as with anything you may have personal biases about—from as many angles as possible, so that you have a better understanding of your beliefs *and why others have different beliefs*.

Every mental health practitioner has had, or will have, to face a time in a mental health setting where their personal beliefs and biases are in opposition with their client’s. Maybe a client wants to explore the BDSM lifestyle and your bias is that it is “unhealthy” or goes against your religious beliefs. Navigating your own process when working with a client whose sexual values are noticeably different than your own takes patience, finesse, and focus. Remember, also, that there are many other sexual topics, experiences, identities, and curiosities that may come up with clients, so the above list is merely a starting place for self-analysis.

## What to Do in These Situations?

Doing a self-analysis of your sexual belief structures will ideally lead you to a place where you can separate your internal reactions from your outward responses to your clients when new or surprising topics about sex and sexuality arise. This separation allows you to bring your highest, most professional responses into the mental health setting and provide the best care possible to your clients.

However, pushing back decades of cultural messaging about sexuality is not a quick or easy task. Many mental health practitioners find that they need substantial support in order to feel completely at ease addressing a wide range of sexual topics with clients. In this case, the *ACA Code of Ethics* section on personal values (§A.4.b.), states that it is your responsibility to seek training in these areas to better assist future clients. The American Association of Sexuality Educators, Counselors and Therapists (AASECT) provides and/or certifies many such trainings around the country. You can find more information about their offerings at <http://www.AASECT.org>.



## All About Sexuality

The field of sexuality is incredibly broad. As a mental health practitioner, there's no way for you to be knowledgeable about all the many different facets of the field. You may, however, have a firm foundation of information about sexuality and know how to access additional information. This will provide you with the ability to talk fluently in session with your clients. What follows in this section is a basic underpinning to provide you with that foundation. The final section in this handbook is an extensive resource list that will point you in the right direction to research a broad range of sexuality topics.

Before we dive deeply into the content, it is important to know that the information that makes up the field of sexology evolves over time. Some areas (particularly the ones that are culturally bound) shift more quickly than others (such as the biological information), but all of them change and grow as we learn more about ourselves as human beings.

Three topics that evolve quickly are gender identity, language, and sexual orientation. Each of these topics is based in a heavily cultural framework that is evolving at a rate impossible to keep up with in print publications and even difficult to keep up with digitally.

On the other side of the evolution spectrum are contraceptives and sexually transmitted infections (STIs) other than HIV, which are based in a fairly stable set of information. But even with 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, an effective vaccine is being tested. Because these events have happened in the last two or three years, anything written before then is out of date on a topic that is usually slow to change.

These shifts over time are why it is important to keep in mind that, while the information printed here is a good starting point, keeping up to date and regularly checking even the basic knowledge you have is a critical step to ensuring that all your information is accurate.

Each of the below topics are likely to be come up in the therapy room but will look different for every client. There is substantially more information about the sexual biological and physiological processes when compared to the sexual emotional and psychological processes. This is intentional, given the assumed expertise of the readers.

As you read the following information, be aware of your emotional reactions to it. If you find the content challenging, you may find it useful to step away and process your reactions. This will leave you more ready and able to address these topics with a client in session.

## Accessing Sexual Health Care

All forms of health are interrelated, and sexual health and mental health are no different. When someone's sexual health is in question, or they think it might be, their mental health clearly suffers. Because of the cultural taboos around sex—which are particularly strong and negative around issues like STIs—top-notch sexual health care is not as thoroughly integrated into mental health care as it could be (Hendry, Snowden, & Brown, 2017). Helping your clients to access kind, supportive, medically accurate, and effective sexual health care can be beneficial to their mental health in addition to their sexual health.

Access to sexual health care can range from relatively easy and affordable to completely inaccessible. What makes the difference can include everything from the kind of sexual health care a person tries to access, to where a person lives, the identities that a person holds, 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 client who is struggling to access sexual health care, it is critical to address each of these constructs.

While Planned Parenthood often offers the most easily accessible sexual health service, there are many places 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 <https://gettested.cdc.gov> and search by any U.S. Zip code.

## Anatomy and Physiology

*Anatomy* refers to biological structures; *physiology* refers to the ways that anatomy functions. The fields of study that investigate and clarify the sexual anatomy and physiology of the human body are substantial. Entire textbooks are written about narrow ranges 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 controversies around genital surgery.

### ***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 and little else. However, this is actually an incredibly complex topic, particularly when a specific individual, rather than population-wide statistics, is the focus of the dialogue.

When working with clients, mental health practitioners have the benefit of focusing in on the specific needs of the person (or small group of people) in front of them. This is particularly important when considering sexual anatomy and physiology. Basing your work in a broad understanding of anatomic and physiologic trends may not be a bad place to start, but it will not move you very far unless you're ready with an open mind about how often individuals do not fall into the norm inside their bodies.

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

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

It is important to keep in mind the various ways that actual bodies differ from a “normal” or an “average” body. In fact, it has been shown in conclusive terms that there are very few people who come anywhere close to the “average” body. While this is useful information when it comes to bodies generally (and will be recalled in the subsection below on body image), it is specifically relevant to sexual anatomy and physiology 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. Nevertheless, starting with averages and then moving to the actual is a useful place to begin.

### ***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 this 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, many people will come into sexual contact with sexual anatomy that looks very different than 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.

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 highly judged 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 realm (i.e., a key component to many people’s feelings of sexual attraction).

Navigating what many people feel is an intense dichotomy (e.g., the innocence of babies vs. the naughtiness of sex) can lead to complex 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 integral 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 that stretch from the clitoris to the perineum, the labia provide protection for the more sensitive parts of the vulva.
- **Mouth**—The mouth is an integral part of many people's sexuality. Through oral stimulation of a partner, from kissing to oral sex, the mouth is a frequently used, but infrequently discussed, part of the sexual anatomy.
- **Nipples**—Intimately part of the breasts for some, but part of 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 at a rate of about once a month into the fallopian tubes during ovulation. If an ovum is fertilized, it 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.
- **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 get 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**—The vagina 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 vagina is often penetrated during sexual activities by a penis, fingers, or other 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 have many different appearances, including 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 it 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 in their 40s or 50s with ovaries experience when their ovaries stop producing hormones. Often the most noticeable impact is that they stop having a menstrual cycle. Other physical impacts may include changes in vaginal lubrication cycles, body temperature, sexual arousal patterns, 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. 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. 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 kinds 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, orgasm is considered critical if a sexual experience is to be considered high quality. 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 stress to 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 begin to look more like adults. 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; 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 for, and pleasurable and connecting when they do. Learning more about anatomy and physiology is useful when it comes to desire and arousal, 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 increased bodily autonomy for all people at all ages is an underlying issue for all elective genital surgery. Here are the three primary foci of that 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 strongly in favor and many people being 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) do 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 feel differently about circumcision from each other, the issue can be fraught with anger, resentment, and a rock-solid 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 in the United States as compared with other countries, genital cutting nevertheless occurs here as well.

There is often an assumption that people who have experienced genital cutting will absolutely 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 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) or "female" (with labia and a vagina).

Historically, doctors have often done unnecessary and harmful surgeries to align the infant's genitals with stereotypically looking genitalia. 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 is generally not harmful in the same way as genital surgery on infants or children may be.

## BDSM

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 growing understanding of BDSM sexual interactions in the public eye. The books (and then movies) *Fifty Shades of Grey* 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 your adult clients are interested in reading BDSM erotica, encourage them to 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.

When working with clients who are exploring their sexual interests, including BDSM, it is important to be supportive and nonjudgmental. This includes minor clients, which can be harder for some practitioners. However, 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. This is due to a number of barriers, including the need for intense self-awareness and the need to learn from others (who are themselves adults, and thus posing a legal and moral barrier).

The “Additional Resources” section of this handbook has reading material on kink that includes BDSM relationships.

## Body Image

The psychology and sociology of the body are deep and complex topics. Our culture provides a specific understanding of what a body “should” look like, and nobody actually has that body. The issue is that the standards by which bodies are judged are dichotomous—they impose definitive goals that are inherently contradictory. Women are expected to be both more and less sexual while men are expected to be both strong and unimposing. While there are deep judgments, it is rarely clear exactly what one should, in fact, look like. The consequences for not having a body that is in alignment with the cultural perception of the idea, which is inherently unobtainable, can include self-doubt, eating disorders, and sexual problems.

The ways that body image and sexuality interact with each other are manifold. Poor body image has the potential to degrade every aspect of sexuality, from attraction and arousal to orgasm. It can draw down on the quality of connections both in and out of a couple's bedroom. Therefore, it is critical to consider the ways that the 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.

The “Handouts” section includes a body image journal that you can use with clients in session to support their understanding of their own negative body image and hopefully build skills to improve it.

## Communication Styles

Communication styles—passive, aggressive, passive-aggressive, and assertive—are a natural and common part of a mental health practitioner’s interaction with clients. However, it is worth noting that many people have a particularly difficult time using and requiring that their partners use an assertive communication style within their romantic and sexual relationships. This difficulty in assessing the quality of the communication within a sexual or romantic relationship is why comprehensive sexuality education is inclusive of 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 falters, trending either toward passivity or aggression. At the times when people feel the most vulnerable, they are most likely to fall back on bad communication habits in an attempt to soften their own or the other person’s potential pain.

Within a mental health setting, it is worth spending the time to address communication within sexual and romantic relationships specifically because they can be so fraught with cultural assumptions, poor media messaging, and ingrained habits. One of the issues with the combination of communication and sexuality is that partner dialogue must be specific even though many people are not fully aware of their own sexual wants and needs. When discussing sexual pleasure and satisfaction, for example, some people don’t know their own bodies’ sexual response cycles sufficiently to be able to clearly explain to a partner how they work. In cases like this, it is important to stress that a person needs to come to understand themselves, through masturbation and/or introspection, in order to be able to fully talk with their partner. Emphasizing the importance of self-knowledge as a path to increased communication with a partner is a very powerful tool in a relationship toolkit.

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

## Gender Identity

Gender identity is a construct that has historically been largely misunderstood. Instead of considering it a unique element, gender identity has been assumed to be the same as a person's sex assigned at birth. Another common, often cruel, assumption has been that people who identified as gay or lesbian were a different gender than their sex assigned at birth. This assumption was based in gender expression rather than gender identity. This inaccurate confluence of gender identity, gender expression, and sexual orientation also has a long and problematic history.

Gender identity is actually a unique element that is often, although definitely not always, connected to sex assigned at birth. "What's Your Identity" in the "Handouts" section includes the following definitions:

- **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.
- **Gender expression**—The way(s) that a person shares information about their gender through their hair, makeup, clothes, etc.
- **Biological sex**—A complex group of physical factors that are variously assigned to male, female, and intersex categories.

As our cultural understanding of the ways that gender identity (which is an internal feeling) differs from gender expression (an external explanation) and sex assigned at birth (a cursory description of the external genitalia) have expanded, we have come to learn that gender identity and the way that it connects or doesn't connect with expression and sex assigned at birth is a critical component of mental health. Not feeling accepted or understood because of one's gender identity can have a drastic negative impact on a person's mental health. Creating a place for clients to feel safe and comfortable to develop and express their gender can have lasting positive impacts.

## Healthy and Unhealthy Relationships

There are so many ways in which a sexual or romantic relationship can be unhealthy, and there are many educational programs that detail those ways. This attention to unhealthy relationships takes up substantially more time in many educational programs compared to discussing and discovering what healthy relationships look like. But people 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. The "Handouts" section includes "Columns and Shadows," which provides insight into teasing apart these sometimes-complex issues while providing a blueprint for relationship health.

Understanding the specific details of the potential aspects of a healthy relationship as compared to an unhealthy one can be incredibly eye opening. For example, what a supportive partner might do when

a person is very 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 language like “supportive” to understand the possible set of actions and deeds one’s partner could bring to the table helps clients contextualize whether a relationship is truly healthy or unhealthy.

## **Intersectionality**

Intersectionality describes the ways that cultural structures intersect with each other to combine impact. This means that not only is it unwise to consider identities individually, but that this actively discounts their overall impact. Intersectionality is most commonly raised as a framework to more deeply understand the institutionalized structures that negatively impact minority groups. Some of the minority identities that are critical to understand in this context include race/ethnicity, gender identity, sexual orientation, health status, disability status, economic status, educational background, and more.

The majority of the structures in the United States are designed to support people who are White, cisgender, male, heterosexual, healthy, typically abled, well funded, and well educated. When a person does not fit into increasing numbers of these categories, there is an exponentially negative impact of being shut out of cultural and economic structures.

One example to highlight the importance of taking an intersectional lens regarding sexuality might be to consider the mental health implications of being a White, straight, cisgender man compared with the mental health implications of being an Egyptian, lesbian, transwoman. While it is, of course, possible that the first person has more mental health issues, the second has substantially more institutional hurdles to overcome in her pursuit of life, liberty, and happiness. People from privileges like money and education may or may not have trauma in their histories, but people from minority statuses always have more societal barriers that can cause mental health issues and traumatic experiences.

Some identities that are potentially less visible, like sexual orientation, education, and some disabilities, impact both the ways that people are related to publicly and the ways mental health practitioners will come to understand and work with them in session. Remembering the possibility of invisible identities and the ways they may intersectionally impact your clients is critical to supporting their mental health.

## **Intimate Partner Violence**

The dynamics of intimate partner violence (IPV) are such that many people are unaware of what a relationship on its way towards violence may look like and what forms violence may take. Forms of violence other than physical violence are often ignored rather than seen as harmful. Many of them are even romanticized in media through movies, television shows, and music. This includes emotional,

financial, psychological, sexual, and social violence. While these forms of IPV are often precursors to physical violence, there are warning signs leading up to these forms of IPV themselves. As early as the beginning of a relationship, you may need to watch for IPV if your partner

- 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;
- 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; and/or
- 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.

Once a relationship is more established, warning signs shift somewhat, but the primary issues of control and manipulation remain. The ways that 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. These are the primary points of concern that a mental health practitioner must take into account when initiating a discussion around intimate partner violence. Using words like *manipulation*, *empathy*, and *love*, rather than *violence*, often allows for an easier entry into the dialogue.

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

## Kink

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 by their kinks rather than accepted because of them.

Most people with kinks need them to be a part of their 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 whom they have been with for years because not including their kink in their sex life is becoming too difficult.

When a mental health practitioner is kink-aware and kink-friendly, they are able to be supportive of clients with kinks. This means the practitioner knows how to support people's internal and relationship processes as they relate to sexual kinks.

## Language

Language describing sexuality is evolving and has always evolved. Because sexuality is mostly culturally hidden rather than openly discussed, there has been a revolving door of slang terms to refer to sexual body parts and sexual acts that reaches 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 clients 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 clients to feel accepted and seen as who they are. In this handbook, for the purpose of creating a space that is affirming and accepting of every identity, we do not use gendered pronouns. Many times, we will refer to the client and use the singular *they/them*. Using these terms in session until you are made aware of the client's preference can create a welcoming and affirming environment. If you use an incorrect word in session, 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 unreasonable. Examples include masturbation resulting in pubic hair growing on the palms and going blind. Most people are not concerned about these things now. Instead, modern concerns about masturbation include it ruining sex with a partner or meaning that they are cheating on their partner, and other physical and emotional concerns.

It is important to reassure clients that masturbation is safe, and that with proper communication it will not 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.

The one concern that may be relevant to a conversation about masturbation is sexual habit. If someone routinely masturbates to orgasm in the same way every time, they may train their body to respond to only that kind of stimulation. Because a partner will rarely replicate a masturbation technique, it may be harder for a partner to bring them to orgasm. The fix for this is relatively simple: First, if possible, the person should vary their masturbation routine so that they are orgasming with different kinds of stimulation. If they have already built a response system, though, it may be that they need to retrain their body. This takes time and dedication. They should stop masturbating in their standard way completely, and instead masturbate with other patterns of touch. Eventually their body will relearn how to orgasm with different kinds of stimulation. The one important caution to remember about this is that there are some people who do require certain kinds of touch (like direct clitoral stimulation or stimulation of the penis or anus). This is not inherently problematic, and a partner will hopefully be able to learn how to engage with stimulating that part of the body.

## Pregnancy and Birth

Pregnancy and birth are intrinsic to our human experiences. 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/or as something that friends and family experience.

### ***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, but even people in their early-to-mid 20s or from particularly conservative backgrounds can be confused about the details. 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. 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 and then one sperm enters the egg. This process is called *fertilization* and the cell structures that are created are called *preembryos*. After fertilization, the preembryo 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 unanimous) agreement that implantation 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:

1. **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 and medications 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. 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!
2. **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 when compared to the first trimester and they usually are not uncomfortably large yet.
3. **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 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:

1. **Stage 1**—This begins with early labor, which is from the onset of regular, rhythmic contractions until the cervix dilates to 3 cm. Active labor is at 3–7 cm cervical dilation, and transition is at 7–10 cm cervical dilation. The first stage of labor is typically the longest, sometimes lasting up to a full 24 hours. Staying calm and relaxed is critical during this stage. Because it can last so long, some people get very impatient and ready for this stage to end. Transition, which is the last part of stage 1, can be physically and emotional difficult.

**2. 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.

**3. 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 vaginal birth 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 and assumptions a client may bring about past or future birth experiences.

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

The decision of how and where to give birth is a very personal one. 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 reiterate with clients who are struggling with where to give birth that the pregnant person feeling well-cared-for is the most critical component of this decision. The same is true for clients who are struggling with accepting where a friend or family member has decided to give birth.

### ***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 be prone to shift. While sexual activity during pregnancy is overwhelmingly safe and encouraged in a committed relationship, the issues that arise can be both physical and emotional.

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 impact 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 prepregnancy norms and even different between trimesters. After birth, many people find themselves exhausted with 24-hour parenting and emotional about their bodies, which are usually different from their prepregnancy bodies. These issues can lead to a reduced sex drive and potentially feeling emotionally distant from their partner.

Some people experience postpartum issues like the “baby blues,” postpartum depression, and postpartum psychosis, which further augment difficulty connecting with anyone from their baby to their partner to other children, family, and friends. The majority of these feelings are based in the body's physical shift in hormones. However, with little cultural dialogue about them, and a common

narrative insisting on a person being overjoyed and full of love and connection postbirth, many people are unaware that there is help available. For these reasons, it is important to pay close attention to people's emotional landscape after birth. Some of the warning signs to look for include mild to severe depression, mood swings, unexplainable crying, irritability, emotional disconnection, etc. It is critical that people who are experiencing these, or even more-dramatic mental health issues, after a birth are in contact with an expert in the field. They need to be formally evaluated and potentially offered medical assistance balancing their hormones.

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. Ultimately, the potential impact on sexual arousal to a pregnant partner may be surprising even for the individual. It is often unhelpful for people to grapple with their own shifts in sexual arousal with their pregnant partner. Rather, it may be more useful for them to come to understand their shifts through dialogue with a mental health practitioner or other person whose insight they value, and then return to dialogue with their partner about their evolving sexual relationship.

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 client, started.

## **Religion**

Religious traditions say so many different things about sexuality that there is no way to contain them within this resource. The most important aspect about the intersection of sexuality and religion to consider in the mental health setting are any discrepancies between a person's identity, behavior, and/or attraction and what their religion prescribes.

Discrepancies between a client's sexuality and their religious traditions can potentially relate to their religion during childhood, their current religion, and even a religion they are considering converting to. These three lenses all provide insight into the ways a person internalizes and assesses the degree to which their sexuality is moral and ethical. When a client does not have a religious affiliation, either during childhood or into adulthood, they are still likely to have a set of sexual values that need to be taken into consideration.

It is important to support a client's understanding of the differences between a religious, moral, or ethical description of what is sexually "right" or "wrong" compared to a psychological or biological description of what is sexually "right" or "wrong." This can be very reassuring for clients. For example, the way that a person thinks about their own masturbation habits may be very different when viewed through the two 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.

Religion and religious beliefs can damage a person's sexual self, but religion can also be supportive of a person's sexual self when it is brought into alignment with who the person is. Taking this perspective can be supportive of clients' development of both their religious beliefs and their sexual selves.

## 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 take into consideration

- what the method prevents,
- how the method works, and
- the method's effectiveness.

### ***STI prevention***

Methods of STI prevention vary by type of infection. 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) and internal condoms (which can be put into the vagina or anus) 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. They are around 80% effective.
- Taking a vaccine. There are vaccines that inoculate the body against HPV and hepatitis infections.
- Taking preventative medication. HIV medication is complex and is 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. 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 to dramatically reduce the likelihood that they will contract the virus.

### ***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; reducing the endometrium in the uterus so that it cannot support implantation; stilling the fallopian tubal cilia so that the zygote does not reach the ovary, etc. Pregnancy prevention falls into five categories that work in different ways:

- **Hormonal**—One of the most common forms of contraception, hormonal birth control works by making either fertilization or implantation impossible. 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.

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.

Two of the 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 within the first 24 hours, and both drop in effectiveness, but can still be taken, within the first 5 days after intercourse.

People have different reactions to contraceptive hormones. In addition to the expected (and hoped for!) 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 often be reduced by changing to a contraceptive with a different balance of hormones. Some people find that they are happier and feel better when they use nonhormonal methods of contraception.

In the United States, hormonal contraception is available only through a health care practitioner’s prescription. There are laws about the age a person can be prescribed hormonal contraception without parental consent; they vary from state to state.

- **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.

Barrier methods range in effectiveness from 80–90%.

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 impact 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, including young teenagers. They are often given out for free at health clinics. The other types of barrier contraception require a prescription.

- **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 100% accurate use, it ranges from 73–100%.

- **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 have the impact of a permanent surgical contraceptive, those procedures are only 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.

- **Chemical**—The only prevention method in this category is spermicide, which 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.

Talking with clients about the many safer sex options is not necessarily easy for mental health practitioners because it is outside of their realm of expertise. However, medical doctors are often overbooked and spend little time per patient, and your clients may find that they are left with questions and are confused about the biological details even after an appointment. The resources section has websites and other sources that may be useful to you and clients as you learn about the various potential options. There is also a resource in the handouts section of this guidebook that will allow you to discuss options with clients.

## Sexual Consent

Consent is one of those topics that is often reduced to simplistic sound bites rather than discussed with all its complexities. While this is not always true, of course, in the mental health field it is important to acknowledge the popular-culture dialogue around consent, the ways in which it is simplistic, and how to deepen it. This is particularly true within the context of ongoing and/or committed sexual relationships.

Two of the most common examples of simplified cultural dialogue about consent are “no means no” and “yes means yes.” Both these perspectives were useful in their historical moment, both add to the conversation, and both are insufficient for a real conversation about consent in daily life. Another example of this 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”). While this is an important talking point in reaction to the trend of young men raping unconscious women, it is also not the entirety of the conversation.

Working with clients who may have internalized one or more of the overly simplified cultural messages about consent, particularly clients who perceive themselves as sex positive, forward-thinking, and aware, is a delicate process of inviting them deeper. One strong approach to this is to discuss questionable examples of consent from movies, television shows, song lyrics, and other forms of media, and discuss them from a variety of ways of assessing consent. There is an example of this kind of activity in the “Handouts” section.

## Sexual Orientation

A person’s sexual orientation is a combination of three aspects:

- **Identity**—This is a combination of the way a person understands themselves internally and the way they describe themselves externally.
- **Attraction**—This is the type of people to whom a person feels drawn romantically and/or sexually.
- **Behavior**—This is a description of the kinds of sexual and/or romantic connections that a person has over time.

For many people all three of these pieces are in alignment, but for others they are not. For people whose three aspects of orientation are not in full alignment, thinking through the independent aspects 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 deeply 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 pieces 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, life-long process. Some examples include making new friends, beginning work in a new place, and having a new mental health practitioner. It may be more appropriate to term this process “self-disclosure” after the initial sharing. Some people find this process of continuous self-disclosure exhausting while others don’t think much about it.

## 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 highly imperfect, 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. 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, a common point of dialogue in sexuality education or popular-culture representations of relationships. Nevertheless, discussing sexuality within a rights-based model may have far-reaching support for individuals who grapple with understanding and accepting their own sexuality. The "Handouts" section includes the World Association of 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 encompasses both pornography and erotica. The difference between the two may be largely semantic, 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 creators' intentions rather than the final product.

To say that SEM is a politically charged topic, both within and outside of the mental health field, would be a substantial understatement. There is not currently consensus 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, 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 impacts the way(s) that 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. When working with clients who struggle with engaging with SEM, it can be difficult to maintain a balanced perspective. Being fully aware of your own personal feelings about SEM and its potential impact on a person’s sexuality is a critical first step.

## 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. 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. Also problematic, the word *disease* 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 language, although if a client is more comfortable using *STD*, there is nothing inherently wrong with using that language when you are working with them.

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

Of the three categories of STIs, each has unique aspects that are important to know.

- **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 a crucial 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. Although a relatively new strain of gonorrhea is not curable by currently known antibiotics, there is a team working towards a vaccine for gonorrhea, which would be very exciting.

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 virus (HPV). There are immunizations for hepatitis and for some strains of HPV.

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

- **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.
- **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).
- **Hepatitis**, which causes liver problems usually characterized by yellowing of the skin and flu-like feelings, can also be transmitted through sexual activity.
- **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.

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 actual 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 as 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 supports your work with clients who may find themselves infected or potentially infected and needing to work through the biological and

the psychological issues that come with those experiences. You may also find clients who shy away from any sexual contact at all because of their fears of contracting an STI. 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 begin to express themselves in ways that people can see and feel. This means that if someone has not been getting regularly tested, a current partner may assume that they have recently cheated because it has recently become clear that they have an STI. This is where understanding the biological implications of a sexually transmitted infection become 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. Without open communication, however, what might have been merely a physical issue can become a physical issue that is convoluted with a trust issue. It is a vulnerable position to be in, though, to disclose an incurable STI. Working with clients on how and when to disclose during a new relationship is often the role of a good mental health practitioner.

## Social Media

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

Take dating, for example. Ads related to seeking romantic engagement first appeared in the late 1600s. Computers figured into the dating world early, in the 1960s, when Harvard students could answer questions and get a list of potential matches. A lot has happened in the last fifty 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 holistic approach to finding romance, there is a dating site to match virtually anyone's needs.

The same general appeal and expansiveness of online dating applies to all social media. There are specific sites and communities that you may be completely unaware of that your clients 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 your clients take part in, invite them to educate you on the parts that they find most fulfilling.

One thing to be aware of, however, 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 and immediate peer structures may not. For young people who identify in ways that are counter to the community around them as it applies to their sexual orientation, gender identity, artistic impulses, personal expression, religious beliefs, 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 that people bully, 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-ana sites are one example, with the goal of supporting anorexia. Two examples are anorexicdiettips.com and myproana.com.

Supporting your clients around sexuality and social media will require you to have a specific understanding of their specific patterns and interests.

There are four aspects of all digital media, including social media, that are important to share with clients 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* gives a comprehensive understanding of the specific issues that digital media brings. The four most important aspects of digital media to remember, according to boyd, are that it holds

- 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); and
- searchability (the ability to find content).

Recalling 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 client participates in.

## **Unintended Pregnancy**

About 45% of all pregnancies in the United States are unintended. When learning that they are pregnant without plans to be so, a person has 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; supportive/unsupportive partners, family, or friends; and more. Clients 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 are 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 has 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 their pregnancy. They 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**—About 40% of unintended pregnancies are ended in a termination. Most commonly referred to as an *abortion*, the termination process depends on how far the pregnancy has progressed from implantation. A termination during the first 10 weeks of pregnancy is possible with a series of pills. Between 10 and 14 weeks, a suction termination is done in a clinic. After 14 weeks, a dilation and evacuation is done.

The cost of a termination depends on which process is needed and how much insurance may pay. They can range up to \$1,000. Laws about terminations vary from state to state but are very rare after 24 weeks of pregnancy. Some states require that minors inform their parents, some require parental permission, and some do not require any parental intervention.

Each of these three choices can be both appreciated and regretted 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 to parent a baby. Having access to full information in order to make an informed decision is critical.

There are two kinds of clinics that provide information about termination and other pregnancy options: abortion clinics (often, but not always, Planned Parenthood clinics) and crisis pregnancy clinics (CPCs), also called *pregnancy resource centers* (PRCs). It is important to understand the differences between these two kinds of clinics. Abortion clinics present medically accurate information about termination with the goal of supporting individuals in making their own decisions. CPCs, however, are created to convince people not to have an abortion, and in order to further that goal, are known to widely disseminate incorrect or exaggerated “facts.” Which kind of clinic one has chosen is critical for clients to know before they go so that they are fully prepared and invested in the kind of support they will receive.



## Handouts

In this section you will find 19 of our favorite handouts to use with your clients. They were developed by UN|HUSHED (which you can download digital versions of here: [unhush.us/MHP](http://unhush.us/MHP)) and other professional organizations. These handouts can be tailored to work with any client in any setting, including individuals, couples, families, and groups. Each handout is accompanied by an overview that includes our suggestions for use. However, we encourage you to adapt these handouts to best fit your and your client's needs.

We encourage you to familiarize yourself with each handout while referring to the “All About Sexuality” section. Then tailor the handouts to the client you wish to use them with. Each client is different, so no handout will be used exactly the same way twice. Only the information that is included with the anatomy handouts shouldn’t be changed; however, how they are introduced and talked about can and should be adapted to each client.

Trust yourself and the knowledge and expertise that you have.



## **“Anatomy” Guide**

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

These handouts are most often used with a client who is in puberty, having questions about their body, or who has incorrect information about their body or a partner’s body. These handouts can be used with clients of all ages; however, refer to your state boards and laws when working with minors.

Before you begin, it is important for you to know that many people make assumptions about a person’s external genitals and their internal anatomy based on the person’s gender expression and that these assumptions are not always correct. Some clients may be trans, although it is common for therapists to be aware of this. Other clients may be intersex, which is less common for therapists to be aware of. The Anatomy and Physiology part of the All About Sexuality section has information about people who are intersex and the Additional Resources section suggests a book that is focused on the experience of being intersex. Introducing Anatomy and Physiology as a point of discussion with your clients in such a way that it is inclusive of intersex bodies is critical. The suggested introduction here is intersex inclusive.

### **A Suggested Introduction**

Tell the client that you are going to discuss sexual and reproductive anatomy. Let them know that every person’s body is special and unique and that no one’s body looks just like anyone else’s - even identical twins end up with bodies that are different from each other. Before you give a client either of the handouts, let them know that if their body is different from the diagrams that you will be looking at, that is normal and natural. Tell the client that most people’s anatomy characteristics fall into one of two patterns that we label female and male. However, there are other patterns of sexual and reproductive anatomy that are called intersex. Let them know that you will mostly be talking about the female and male patterns - but they should know that other patterns exist and that you can talk about them together. If they have questions or want to talk more about what it means to be intersex, you will probably have to do some additional research and talk about it in following session(s).

Provide the client with either one or both of the handouts and 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 clients due to vulnerable and uncertain feelings concerning their body. Allow time for the client to adjust and process the topic. Validate your client’s insecurities, or possible confidence, on the topic.

Throughout the discussion, evaluate and validate how your client 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.

### ***Female anatomy***

- Tell the client that this is a side view of the abdomen of someone with the pattern of anatomy called “female.”
- Point out the anus, and explain that it is attached to the 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 typically travel up through the uterus into both fallopian tubes, where they can potentially fertilize an egg, if present.
  - When menstruation occurs, tissue and blood is shed from the uterus and exits 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 client that this is a side view of the abdomen of someone with the pattern of anatomy called “male.”
- Point out the anus, and explain that it is attached to the 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 of 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 client if they have any questions about the handouts or the descriptions. Allow them time to process any thoughts, feelings, and questions they may have. You may want to let them take the handouts home, think about them, and return to discuss in the next session.

Some possible questions you could ask your client include:

- How were you feeling as we discussed this topic?
- Did you learn anything new?
- Did you learn anything new 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?

## Notes

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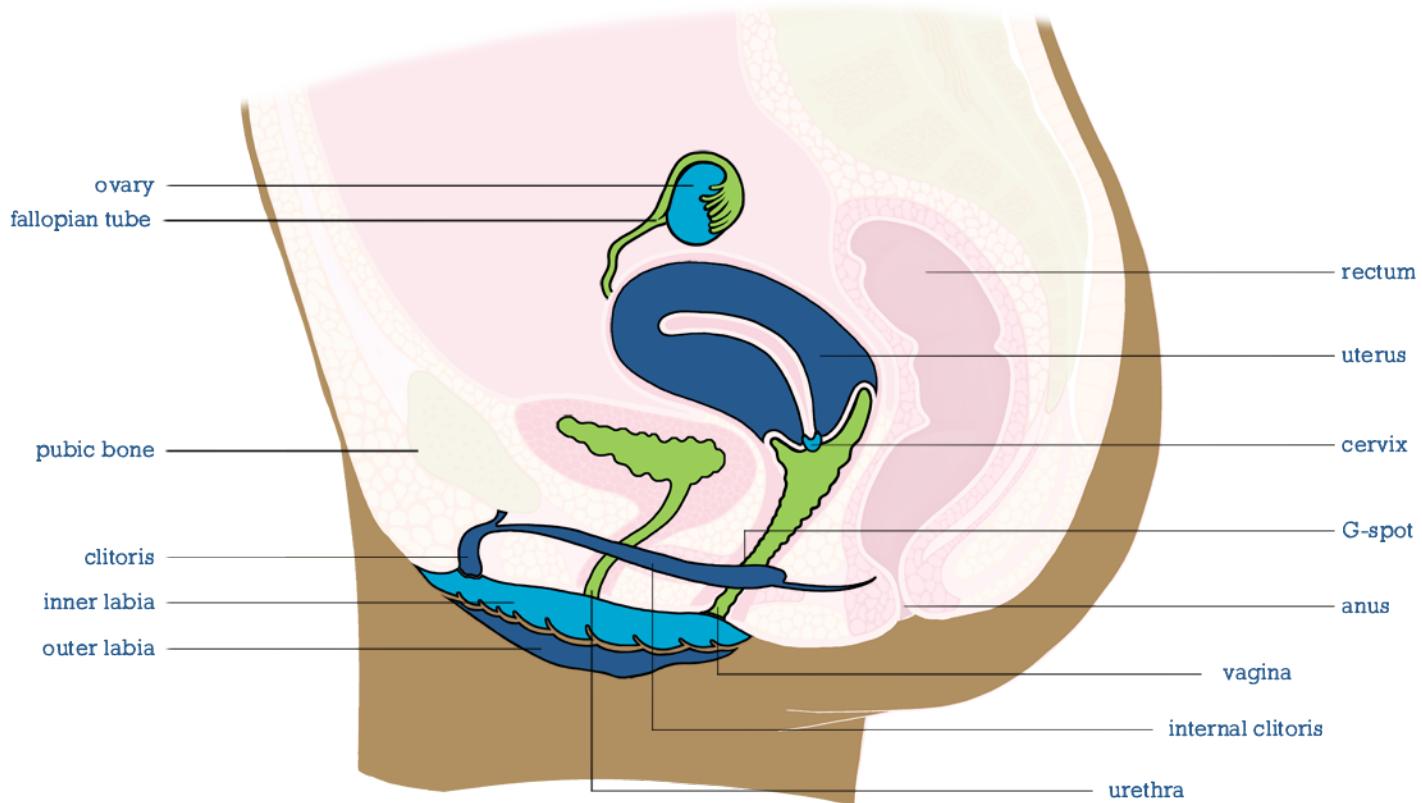
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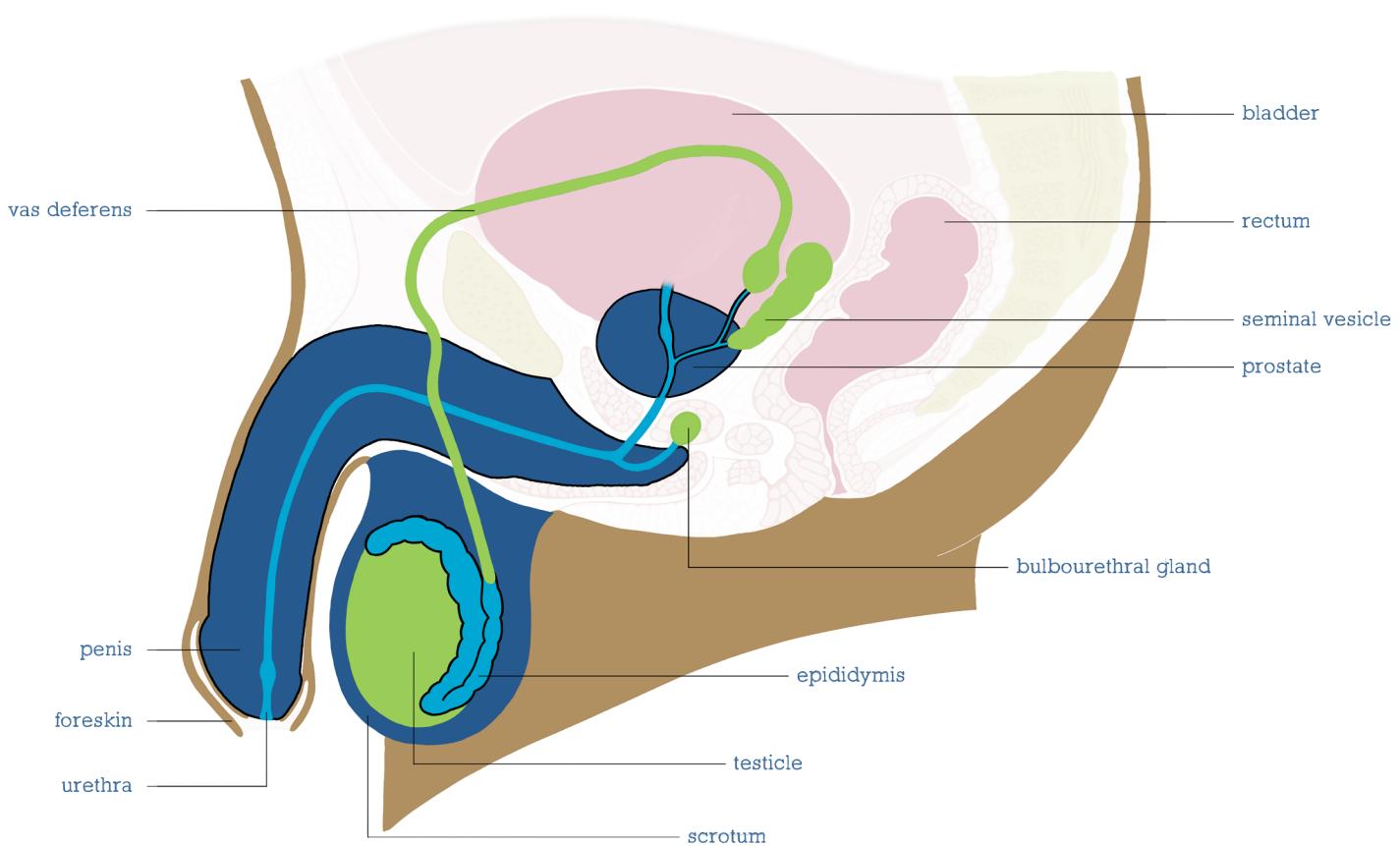
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## Anatomy: Typical Female



## Anatomy: Typical Male



## “Body Image Journal” Guide

The “Body Image Journal” is a simple handout for clients of all ages to address body image issues. It is also a great tool for mental health practitioners to use to teach clients how to rephrase negative thoughts into positive ones. For a refresher on how body image can affect a person’s sexuality, see the body image subsection in “All About Sexuality.”

### A Suggested Introduction

This handout can be given to clients who have a history of body image issues. Let the client know that sometimes it is beneficial to track our moods so that we are conscious of them. It is even more important to catch consistent negative thoughts and rephrase them into positive ones.

Before using the journal handout, it is important to understand that it is meant to celebrate positive thoughts and feelings as much as it is to become aware of and rephrase negative ones.

The Body Image Journal has four sections: body part, negative or positive thought/feeling, intensity level, and positive rephrase. Get familiar with the “Intensity of Experience Scale” at the top of the handout. This scale shows values from 1 (low intensity) to 10 (high intensity). It is meant to measure levels of intensity of both positive and negative experiences.

Explain to a client that when they experience either a positive or negative experience (thought or feeling) to write down the body part, write the positive or negative thought or feeling they had, and then select an intensity level between 1 and 10.

The last column, positive rephrase, is for when the client experienced a negative thought or feeling about a body part. Have the client think about a way to rephrase their negative thought into a positive one. For example, if a client writes “nose” (for body part), “I hate my nose, it’s so big” (for negative thought/feeling), and “7” (for intensity), they may write something like the following in the positive rephrase column:

- “My nose is great the way it is.”
- “All noses are different and mine is just right for me.”
- “My nose reminds me of my grandmother’s cooking when I smell cinnamon.”

The purpose of this journal is to increase the client’s conscious awareness of negative thoughts and feelings they experience about their body and to train their minds to rephrase these positively. This handout also celebrates the positive thoughts and feelings that the client already experiences.

## A Suggested Wrap-Up

Many clients may have issues completing this handout because it causes them to face their vulnerabilities. Encourage and validate your client's feelings. Let them know that homework assignments can be difficult, and that perfection is never the goal.

For clients who experience body image issues, the most difficult parts of completing this handout are often finding positive thoughts and feelings and rephrasing negative ones. Having the client practice this with you in session can build the tools to make this process easier. If you feel that having your client complete the entirety of the handout will be too intense, you can ask them to complete the first three columns for homework and then work together on the last column in session. You may need to do this with clients over a long period of time until they can do it consistently on their own. The important thing is to have the client process each thought and feeling until they get the hang of the tool.

Also, don't forget to celebrate the positive thoughts and feelings **whenever** they experience them!

## Notes

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# Body Image Journal

## Notes

## “Columns and Shadows” Guide

“Columns and Shadows” was developed by Sam Killermann and Dr. Rayne. The handout is a great way to (re)introduce the concepts of healthy and unhealthy relationships to clients. This handout can also be useful for clients who are just starting to date, currently in an unhealthy relationship, or who have a loved one currently in an unhealthy relationship.

### A Suggested Introduction

Make sure that your client knows that there are many ways to think about whether a relationship is healthy or unhealthy and that these things are not always obvious. This model is most helpful for understanding actions and comments that may be unhealthy in a sneaky or less explicit way.

Show the handout to the client and explain that there are four criteria that determine if a relationship is healthy or 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 (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 shine a light on 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.

With the client, read through the bottom two boxes on the handout, “A Healthy Column of R.E.S.T.” and “An Unhealthy Shadow of R.E.S.T.” Then ask the client 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 client 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 be triggering in different ways. For example, if a client has experienced an abusive relationship, this may remind them of what that felt like. However, this activity could help a client realize they are currently in an unhealthy relationship, which could be a first step towards positive action.

## Notes

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## 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.

## Notes

## “Communication Styles” Guide

Communication is a critical component of healthy relationships. Many people do not know much about different communication styles, including what they are, their definitions, the one they use the most, or the one they should be using to support themselves, their partner, 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/or romantic partners. This handout facilitates in-session dialogue about issues relating to all four of these communication styles.

### A Suggested Introduction

Tell the client there are four communication styles most frequently used in relationships, and three of them are unhealthy. Write the names of the four types of communication on a piece of paper and look at them with the client. Invite the client to describe, to the best of their ability, what each communication style might be. Use the following definitions to support the client’s process.

- **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 is not 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 only healthy 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 respecting yourself and those around you. It is about honesty and integrity. 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."

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

## Mix and Match

This activity can be introduced into session 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 client 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 client and discussing why they fall into each category. This activity could also be used as a role-play, depending on the client's comfort level. Explain to the client that the tone of the person speaking can cause the style of communication to change even when the words are the same. Encourage the client to practice saying different examples in different communication styles.

## A Suggested Wrap-Up

This activity can be both fun and informative. Ask the client about the various communication styles that they hear in their day-to-day life. Encourage the client to pay attention to which style people respond positively to most. This assignment could be completed by having the client write their thoughts and experiences in a journal similar to the "Body Image Journal" handout, but modified so that the four columns are: (1) statement/question; (2) communication style; (3) intensity; and (4) assertive rephrase.

## Passive Communication Style Prompt Slips

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

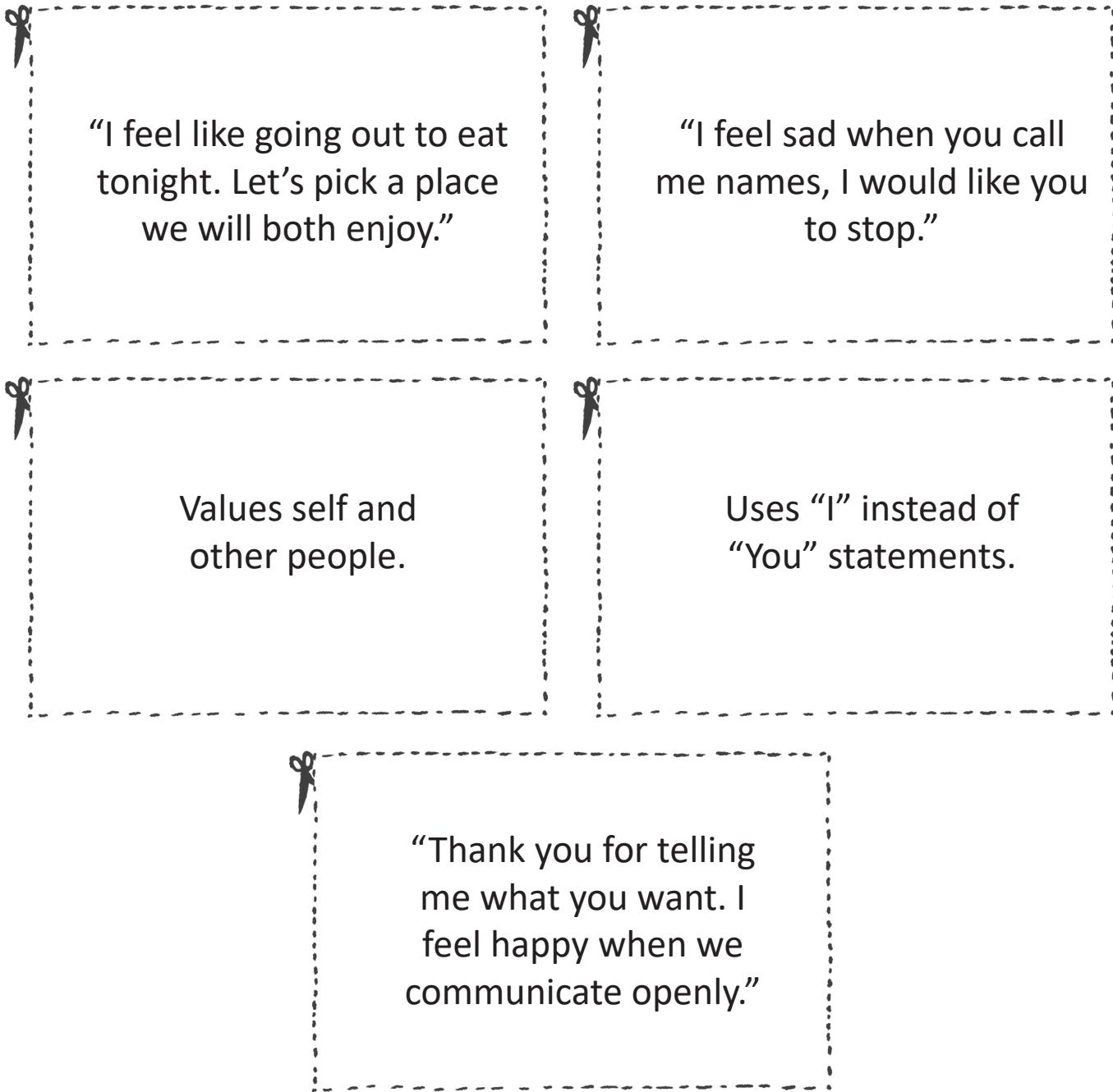


Interrupts and “talks over”  
people.



Only considers their  
own feelings and makes  
demands of others.

## Assertive Communication Style Prompt Slips



## “Condoms, for Fact’s Sake!” Guide

Many people assume putting on a condom is easy—that it is simple and intuitive. But if this were the case, far fewer pregnancies would be unintended and far fewer STIs would be transmitted. However, 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 handout on condom use, which is more of an instruction guide, is designed to support your client in reaching that 98% effectiveness rating when they use condoms. Going over the steps of how to use a condom is always worth the time when you have a client 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—it merely encourages them to have safer sex. Most people, when faced with a situation where they want to have sex but don’t have a condom, will choose to have condomless sex.

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

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

### A Suggested Introduction

It is important to normalize the handout as much as possible. Let the client 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 client if any step or information was new or surprised them. Even after the steps are discussed it is important to normalize and remove judgment from your conversation.

It is likely that the client will have questions concerning condoms other than how to put one on. Additional questions may include the following, adapted from Rayne and Smarr (2019):

- Can you feel anything through a condom?

Yes, you can. There are many activities a client can do alone or with a partner to demonstrate this. For example, have the client 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 client to feel the touch.

- Is the condom too small?

Suggest that the client 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 to specific measurements.

## 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 client should not take care of their sexual health by not using condoms. Encourage the client to get more comfortable with condoms by playing with one on their own before using one with a partner. Feeling uncomfortable putting a condom on can be a roadblock to using one during sex. Exploring oneself and condoms at the same time can release some of these fears and worries.

## Notes

# 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

## “Consent” Guide

Consent is being discussed a lot in the media, in the government, on school campuses, and just about everywhere else in the wake of massive sexual harassment and assault scandals. Dr. Rayne developed these handouts to introduce consent to adolescents, but they can be used and discussed with clients of any age. These handouts can be beneficial for clients starting puberty and/or exploring sexual activity, and for parents or loved ones wanting to speak about consent with their children.

There are two ways that 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.

### A Suggested Introduction

Ask the client what they think about when they hear the word *consent*. Discuss and process the client’s answer. Explain to the client that consent is more complicated than people often think it is. 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.

Give the handout “Consent, Part 1: No Means No” to the client. Read through the description and the scenario and then go through each question. Ask the client whether they think that “no means no” is a good way to determine whether consent was given or not and why. Repeat with the handout “Consent, Part 2: Yes Means Yes.”

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

### A Suggested Wrap-Up

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

- What differences did you notice between each handout?
- Did you feel there was anything missing from either of these ideas of consent?

Encourage your client to continue to explore their ideas of consent. Movies, television shows, song lyrics, and books all provide ample examples to draw from in conversations about consent (although they are rarely positive examples). Continued discussion will be needed. You can encourage your client to keep a journal with thoughts on consent and how they see it represented in the media. This will allow your client 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

## “Contraceptives” Guide

The handout on contraceptives 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 clients who are interested in starting or changing contraception, a client (or parents) 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.”

### A Suggested Introduction

Ask the client what contraceptive or birth control methods they already know about. Many may say 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 client 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 client with the handout, review the process of conception with them: For conception to occur, sperm must leave the testicles and penis and enter the vagina. It then must make its way up the 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 several medical interventions that can induce conception that are different from this process.)

Provide the handout to the client and review the four ways that the four types of contraceptives work. Many clients may have additional questions, so be sure to read the safer sex subsection in “All About Sexuality.”

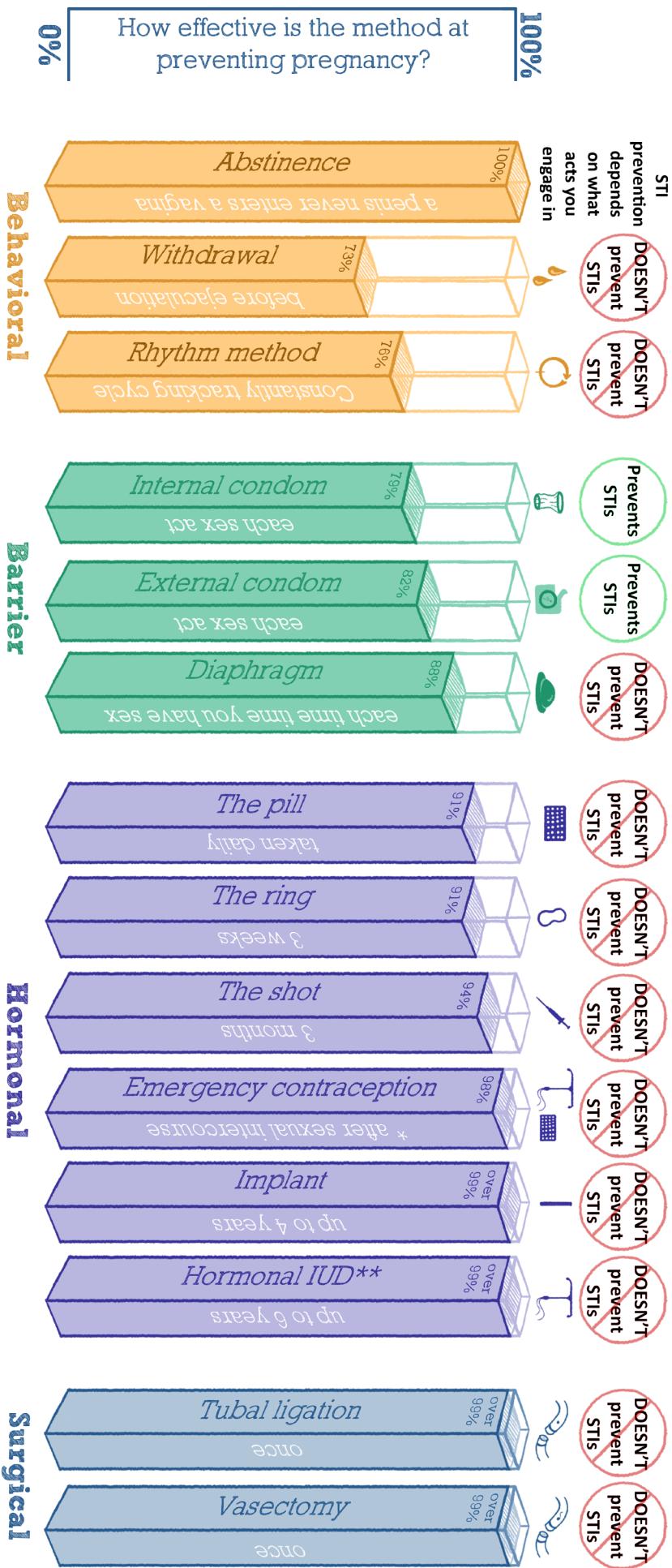
### About STI Prevention

It is imperative that the client understands that most contraceptives are not used to prevent STIs. Address this common misconception with the client, noting that condoms are the only contraceptive method that prevents STIs.

### A Suggested Wrap-Up

Encourage the client to take the handout home with them and to do their own research, including talking with their medical doctor. If you are working with a minor, and it is safe to do so, discuss the need for contraception with parents 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



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>

## “Declaration of Sexual Rights” Guide

The World Association for Sexual Health (WAS) created an in-depth list of sexual rights in 1997, and has since updated it twice, most currently 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 mental health practitioner, and for your clients who may be struggling with their sexuality and sexual health. The Declaration of Sexual Rights can be particularly powerful for clients 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.

### A Suggested Introduction

Ask your client 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 client if they know of any other rights that everyone in the United States is supposed to have. (Look at <http://www.billofrights.org/> for a refresher.) Note that none of the rights in the United States, however, are about sex or sexuality. Ask your client if they can think of a right about sex or sexuality that *they think* everyone should have. If they have ideas for more than one important right about sex or sexuality, write them out together.

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

### For More Information

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

# 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.*

From "Declaration of Sexual Rights" by World Association for Sexual Health, 2014 ([http://www.worldsexology.org/wp-content/uploads/2013/08/declaration\\_of\\_sexual\\_rights\\_sep03\\_2014.pdf](http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf)). Copyright 2014 by World Association for Sexual Health. Reprinted with permission.

## “The Egg in the Reproduction Process” Guide

This handout shows the egg’s progress in the process of ovulation, fertilization, and implantation. This handout was developed by Dr. Rayne and Jessica Smarr, MPH, of UN|HUSHED. It can be used with clients of all ages to discuss these biological functions.

This is an educational handout that can be used for many different clients, whether the purpose is completely educational or for preventative reasons. Not knowing the details or misunderstanding this process can be detrimental to clients. Many people do not understand the reproduction process, a problem that can lead to both physical and emotional issues. Unwanted pregnancy and family arguments are just two possible examples.

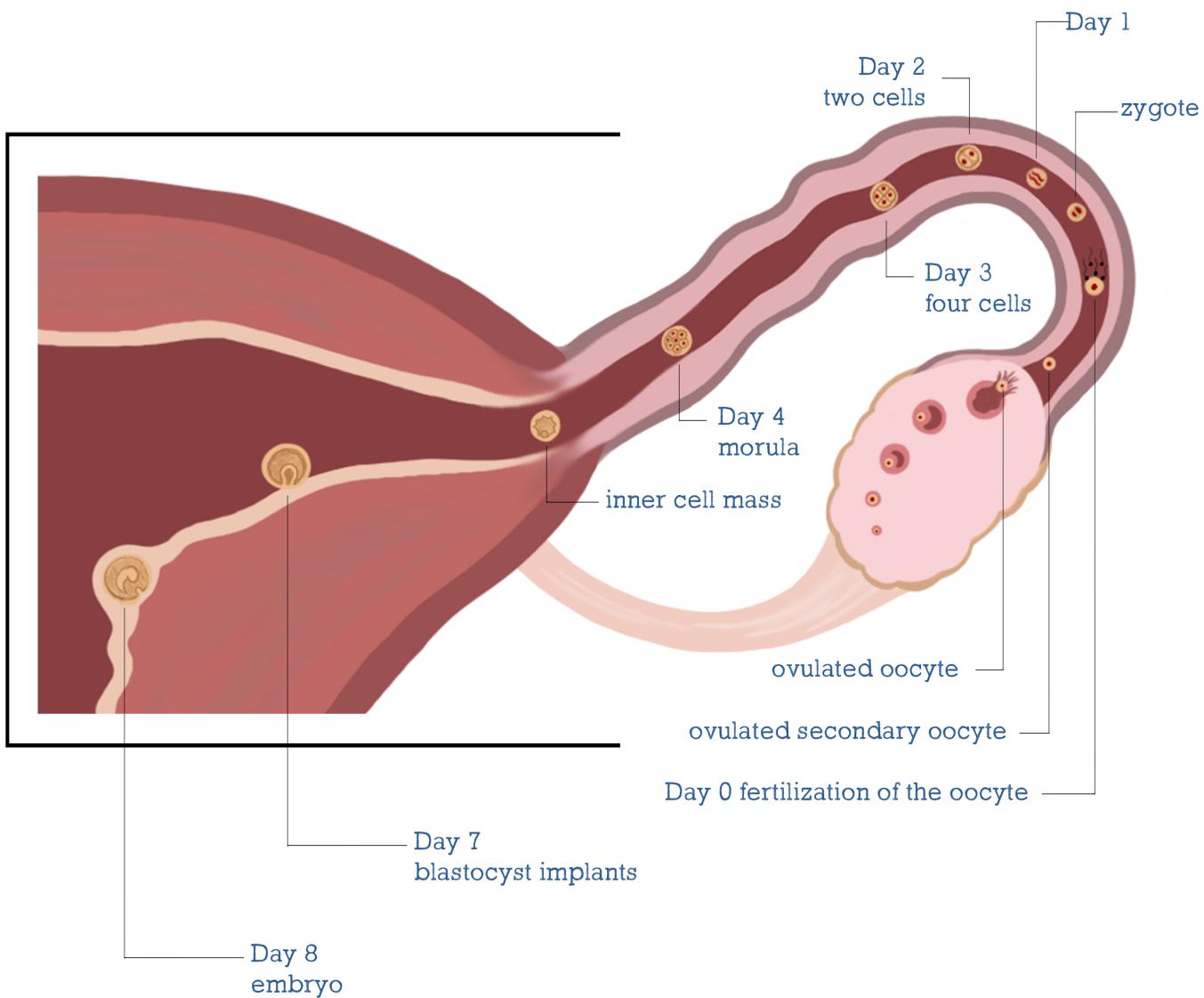
This information could be useful for clients beginning to experiment sexually, single parents looking for information to provide to their children, couples wanting to **prevent** or **cause** a pregnancy, and clients who want to have a better understanding and sense of control over their own bodily functions.

### The Process

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, 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*), implant into the wall of the uterus. If the cells continue to develop, they can become a fetus and eventually a child.

# The Egg in the Reproduction Process



## **“Gender Dictionary” and “Orientation Dictionary” Guide**

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 always visit [unhushed.org](http://unhushed.org) and sign up for a free account to download the most up to date dictionaries.

Also, please be aware that the definitions included here offer only one of many potential ways these terms may be defined. Your clients may come with their own definitions based on their culture 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 client discloses their gender or sexuality to you, ask what it means to them, even if they identify as female, heterosexual, gay, or lesbian, terms you may feel are fairly self-explanatory. Each client has a different experience and knowing their definition and experience will aid you in your work with them and with every other client you encounter.

### **A Suggested Introduction**

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.

These dictionaries can be used with a client if they are questioning their gender or sexuality. Providing one of these handouts for the client to explore with you and on their own can support their understanding of the many ways that people understand, think, and talk about gender and/or orientation. It is important to let the client know that identity questioning and exploration is completely normal and natural and that it isn’t something that needs to be rushed.

You may also use these handouts to support clients 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 your client knows that these dictionaries offer just one of the possible definitions for each term and that each person experiences their identity differently. Use these dictionaries as starting points rather than as a closed set of information.

### **A Suggested Wrap-Up**

Encourage clients 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 client, you may need to prescreen the examples. Good places to start include <http://imfromdriftwood.com> and <https://itgetsbetter.org>.

## Gender Dictionary

These are words that are useful for mental health 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. Some of this language will be familiar to you, but you may not have had a specific definition to use if a client were to ask what exactly it meant. Some of these words 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 one that is 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 perform 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. **Femme**—A feminine-expressing person; usually refers to a lesbian or gay man whose gender roles are typically categorized as feminine.

**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.

**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 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) that 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 aligns 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 assigns to a specific sex assigned at birth.

**Gender norms**—The indicators that a culture assigns to specific sex-related biology, 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 (GSRD)**—This describes the wide range of identities that are referred to with 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 sex assigned at birth, and sometimes discovered after birth, 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 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.

**Pass**—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.

**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 between females and males.

**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 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 facilitators to know and be able to use fluently in activities about sexual orientation. Some of this language may be unfamiliar to you, particularly because it evolves quickly. Some will be familiar to you, but you may not have had a specific definition to use if a participant were to ask what exactly it meant. Some of these terms are not appropriate to use; 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 person who is told what to do in a sexual relationship. This term is often used to describe a person who is penetrated during sex, but it may also refer to 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 co-workers 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* is the preferred language.

**Dyke**—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**—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, it 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, it 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 that a person engages physically with themselves and/or others that engages the genitals and/or involves pleasure and orgasm. People are in control over 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) that 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.

**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 person who decides what to do in a sexual relationship. This term is often used to describe a person who penetrates their partner during sex, but it may also refer to the person with more power in a relationship with consensual psychological or sexual power dynamics.

## Notes

## **"Intimate Partner Violence: Types" Guide**

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 (National Coalition Against Domestic Violence, 2015). 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; emotional and verbal; physical; stalking; and financial. It is useful to pair this handout with others, such as "Columns and Shadows" and "Communication Styles."

### **A Suggested Introduction**

A trauma-informed lens is paramount to introducing this information in a way that is effective and supportive rather than retraumatizing.

This handout can be used for prevention or intervention, depending on the client's needs. Provide the handout to the client and discuss each of the five types of IPV. Remember to validate their feelings and process thoughts throughout the discussion.

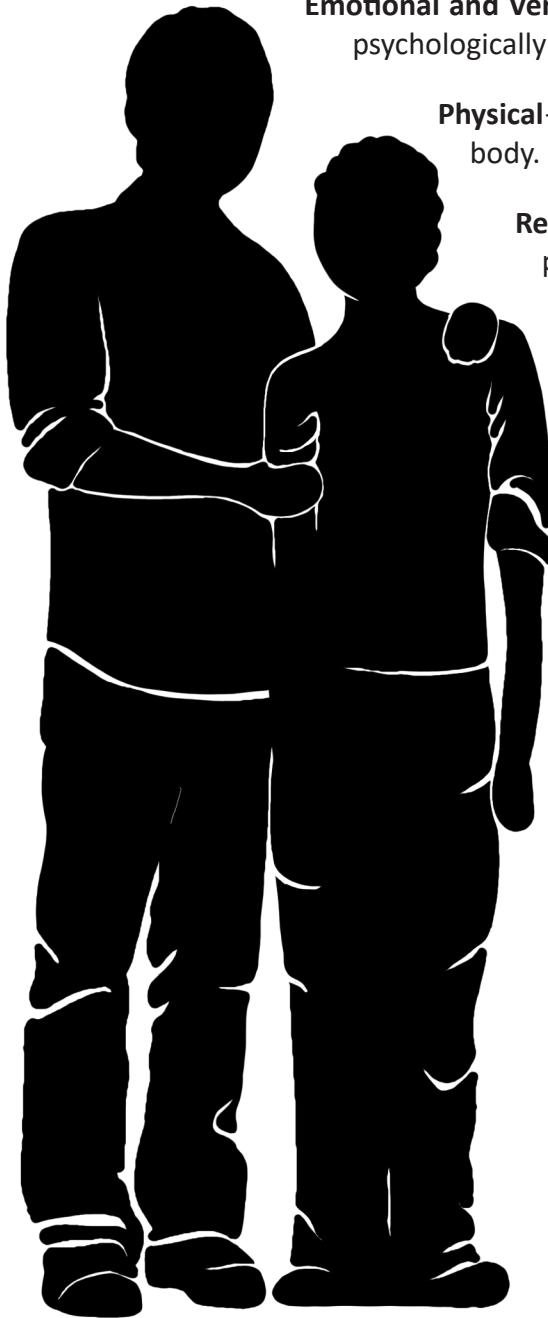
Pairing this handout with the "Columns and Shadows" model can allow you to introduce less-explicit forms of IPV. Combining these two handouts may be a gentler approach to a conversation about relational violence. Use similar examples from the "Columns and Shadows Guide" to discuss how they connect with the five types of IPV. 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).

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 told how "beautiful" or "sexy" you are
- Not being "allowed" to pay
- Being kissed without your permission / enthusiastic consent

One way to explore this activity could be by using popular movies and television shows that the client has seen. Allow the client to describe the scene and process the information from there. Depending on your client's experiences, this activity could be triggering. Process their reactions in addition to their past experiences as much as you can without overwhelming the client.

## Intimate Partner Violence: Types



**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:

- Love Is Respect  
<https://www.loveisrespect.org/>
- Teens Experiencing Abusive Relationships  
<https://www.teensagainstabuse.org>
- The National Domestic Violence Hotline  
<https://www.thehotline.org/>
- Teen Dating Violence  
<https://www.teendvmonth.org/>

## **“Love Pressure” Guide**

This handout assists clients in examining their expectations of love and the impact their culture (including family, friends, religion, school, etc.) has had on these expectations and potential frustrations. When introducing this topic with a client, ask them what love means to them and how they came up with that meaning.

This has the potential to be difficult for a lot of clients. Give them space to explore their thoughts and feelings while assisting in processing them.

### **A Suggested Introduction**

Love is hard and almost everyone has their own definition and meanings concerning what love is. Love is embedded in most parts of culture, especially media, and expectations are passed down generation to generation resulting in historical associations that can either be difficult to understand or can be completely unconscious.

Provide the client with the handout and encourage them to take their time reading and answering the questions. Assure them that they do not have to share their written answers with you and that they can just discuss their thoughts and feelings aloud.

### **A Suggested Wrap-Up**

This activity has the potential to affect some clients deeply depending on their personal histories. Make sure to leave time for ample discussion and to process their thoughts and feelings. Here are some helpful questions to assist in discussion:

- What was easy or difficult about completing the handout?
- What, if any, themes did you notice while filling out the handout or during our discussion?
- Did any certain expectations you have about love stand out to you?
- What is your biggest take away from completing this handout?

## Love Pressure

**Instructions:** Answer the questions below on your own. You will not be required to turn the handout in or share what you wrote down; however, there will be a discussion about these questions.

1. When it comes to love, I feel as though I'm expected to ...
  
2. I feel that expectation comes from my (circle all that apply) family/friends/partner/faith/society/other:
  
3. Love is supposed to be like ...

according to:

4. What I want out of love is ...
  
5. If what I'm experiencing is different from expectations, I will ...

## “Ringerangeroo and Doodle-Dasher, Too” Guide

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 <http://thetimelinesofslang.tumblr.com/>. You can also go to the UN|HUSHED website and play an online version of this game designed by Nyk Rayne—[unhush.us/ringerangeroo](http://unhush.us/ringerangeroo)

This handout can be used to normalize sexually explicit language in a mental health setting. 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 your client have a common language to discuss sexual activities.

When you are not clear on the meanings of the words that you use, even language that you may assume is mutual may not be. For example, some people (especially young people) may believe that *oral sex* means kissing. Whether you agree to use the often-amusing historical language included here or language that your client brings to the conversation, you will know you are on the same page rather than guessing or assuming what they mean.

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

### A Suggested Introduction

Ask the client 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 associated with each “base.” If a client has not heard of this ask them to brainstorm ways either they have talked about, or heard others talk about sex.

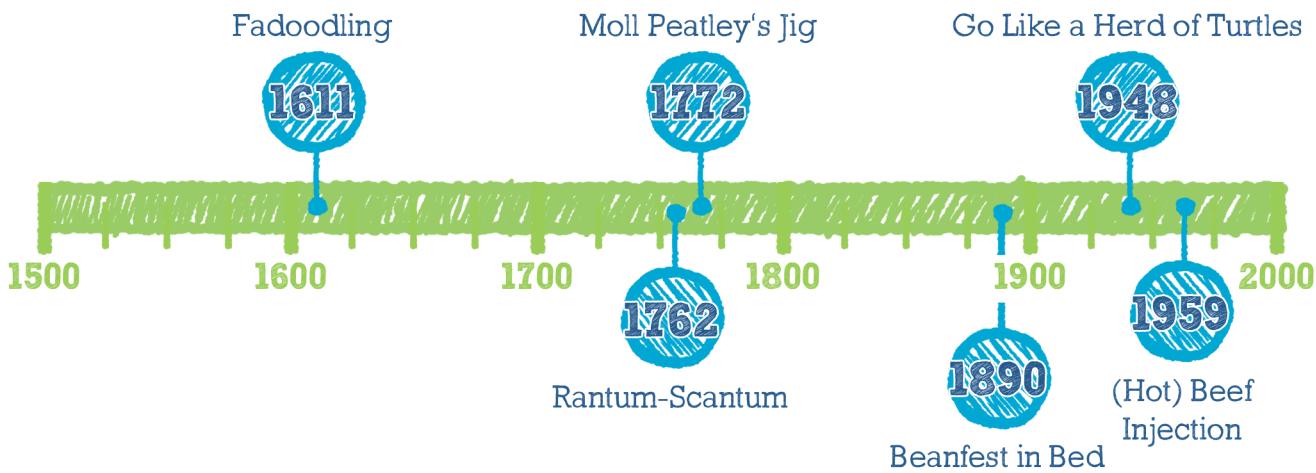
Next ask the client if they have ever heard of sexual activity being compared to pizza. If they have not, or even if they have, take a minute to watch Al Vernacchio’s Ted Talk on the subject of sexuality as a pizza at <https://www.youtube.com/watch?v=xF-CX9mAHPo>.

Provide the handout to your client 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.

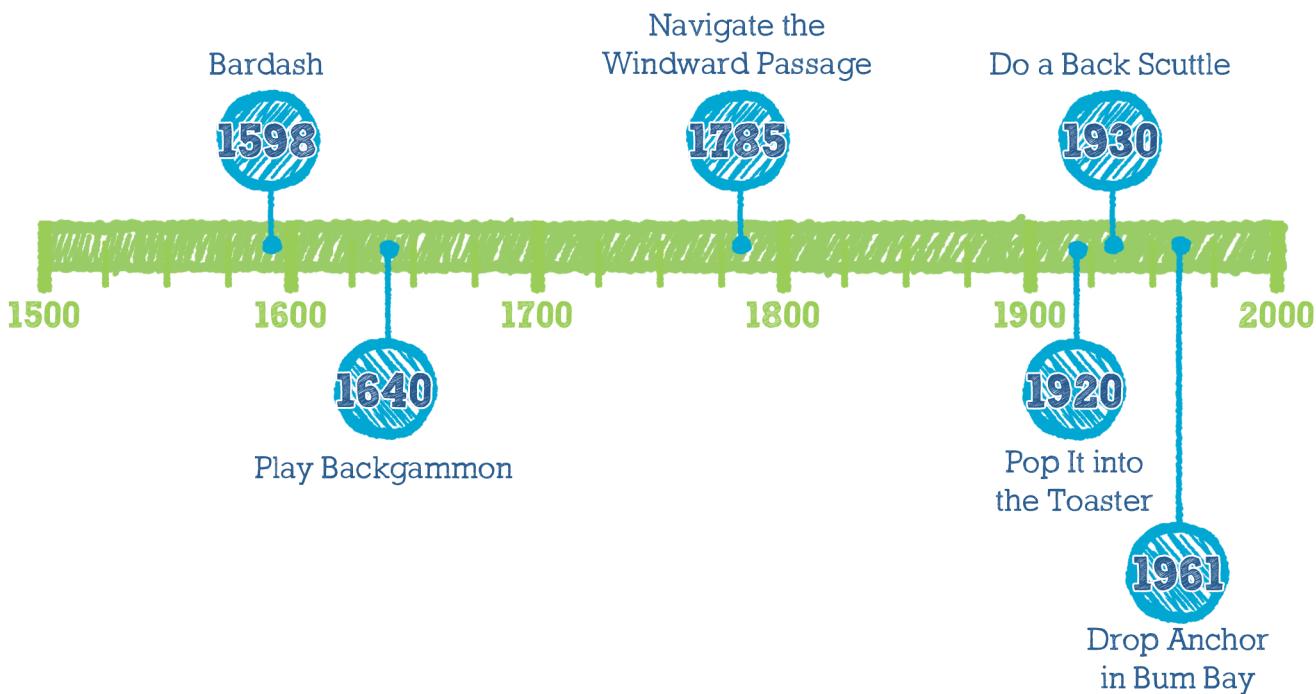
Read over the different historical terms for each of the four primary kinds of sexual activities listed on the handout. Check to make sure your client fully understands what the four types of sexual activities actually entail. Ask your client what words they and their friends use, and write those in 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.

# Ringerangeroo and Doodle-Dasher, Too

## Vaginal Intercourse



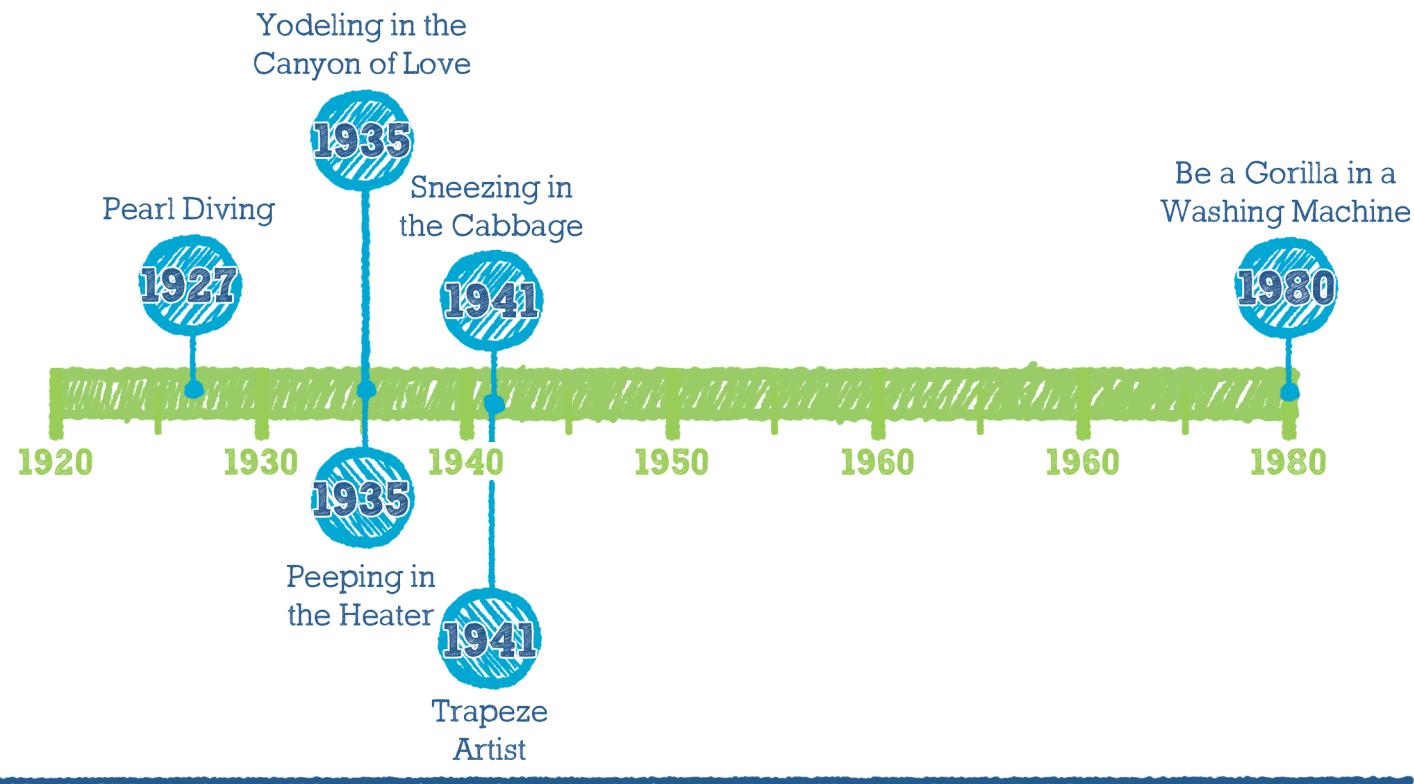
## Anal Intercourse



## Ringerangeroo and Doodle-Dasher, Too

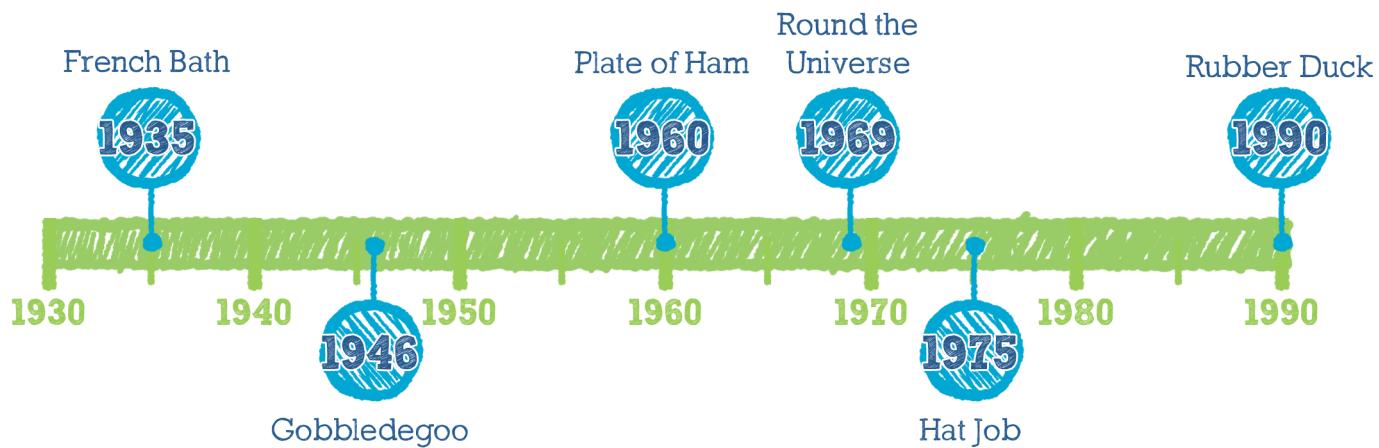
### Cunnilingus

(Oral sex involving the vulva)



### Fellatio

(Oral sex involving the penis)



## Notes

## **“Sexual Harassment” Guide**

This is a simple handout that provides examples of what sexual harassment is, specifying four categories of harassment: digital, verbal, physical, and power imbalance. This handout is useful for clients of all ages who are grappling with deepening their understanding of appropriate and inappropriate boundaries. Some clients will find it useful to understand and react to other people’s inappropriate interactions with them. Other clients will need it to more deeply understand why their own actions are problematic.

### **A Suggested Introduction**

There are many ways to introduce this handout. One way is to simply ask, “What is sexual harassment?” Discuss the client’s response and if appropriate ask a follow-up question like, “How can you tell when someone is being sexually harassed?” The client’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.

Talking about sexually harassing behavior from popular media such as movies, television shows, books, and music can be helpful. Come with several examples and ask your client if they have seen or heard about these examples. You may even have some example YouTube clips prepared for this session. After you have introduced your clips, ask the client if they can think of any additional popular media examples.

Challenge your client to critically think about times they have seen sexual harassment in their daily lives at work, school, church, restaurants, on the street, etc. Discuss and process these examples with your client.

Remember that this topic and handout may be triggering to some clients, so keep a trauma-informed lens on at all times.

# **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

## “The Sexualitree” Guide

The “Sexualitree” is a tool developed by Sam Killermann and Dr. 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. Please visit <http://www.sexualitree.org> for extended details and examples.

### A Suggested Introduction

The Sexualitree can be used with a wide range of clients and tailored to work with different groups of people. One way to introduce the concept is to ask a client how they would define the words *sex* and *sexuality*. Here are formal definitions you can use to support the client’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 the 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 ways that people want to have sex, including their emotions about and their physical reactions to other people, and
  - the many ways that 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 client the 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 do identify with and people who 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’re actually talking with them, 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 the ways that you feel and think about sexuality, and may influence your physical, sexual, and emotional health. Leaves of a tree grow and change with some frequency, just like a person’s sexuality and how and with whom they are sexual changes over their lifetime.

Allow the client to share their initial thoughts with you. Next move on to talking about the elements of sexuality. There are potentially hundreds of elements of sexuality, including anything that impacts 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 condoms element 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 so 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, many different elements of sexuality. You may find it useful to download a blank version of the Sexualitree from <http://www.sexualitree.org/> so that your client can include only those elements that are most relevant to them. You may also prefer to use the simpler, blank version with younger clients, and you can provide more verbal explanation.

## A Suggested Wrap-Up

Either for homework or during the session, have the client 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. Here are a few examples, and more can be found at <http://www.sexualitree.org>.

- **Adults**—You might discuss the full lifecycle of the tree, inviting clients to consider how their long-standing roots (culture) and slow-growing base (relational) histories inform their current intimate relationships.
- **Teenagers**—You might use the tree as an opportunity to discuss long-term goals, and how the clients' 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.
- **Parents**—You might talk about how they are setting the cultural soil from which their children will take nourishment, the social systems in which their children will develop strength, and the environment in which their children will develop their own intimacies.

This handout is one that you can keep referring back to as the client develops and explores their sexuality.

## Notes

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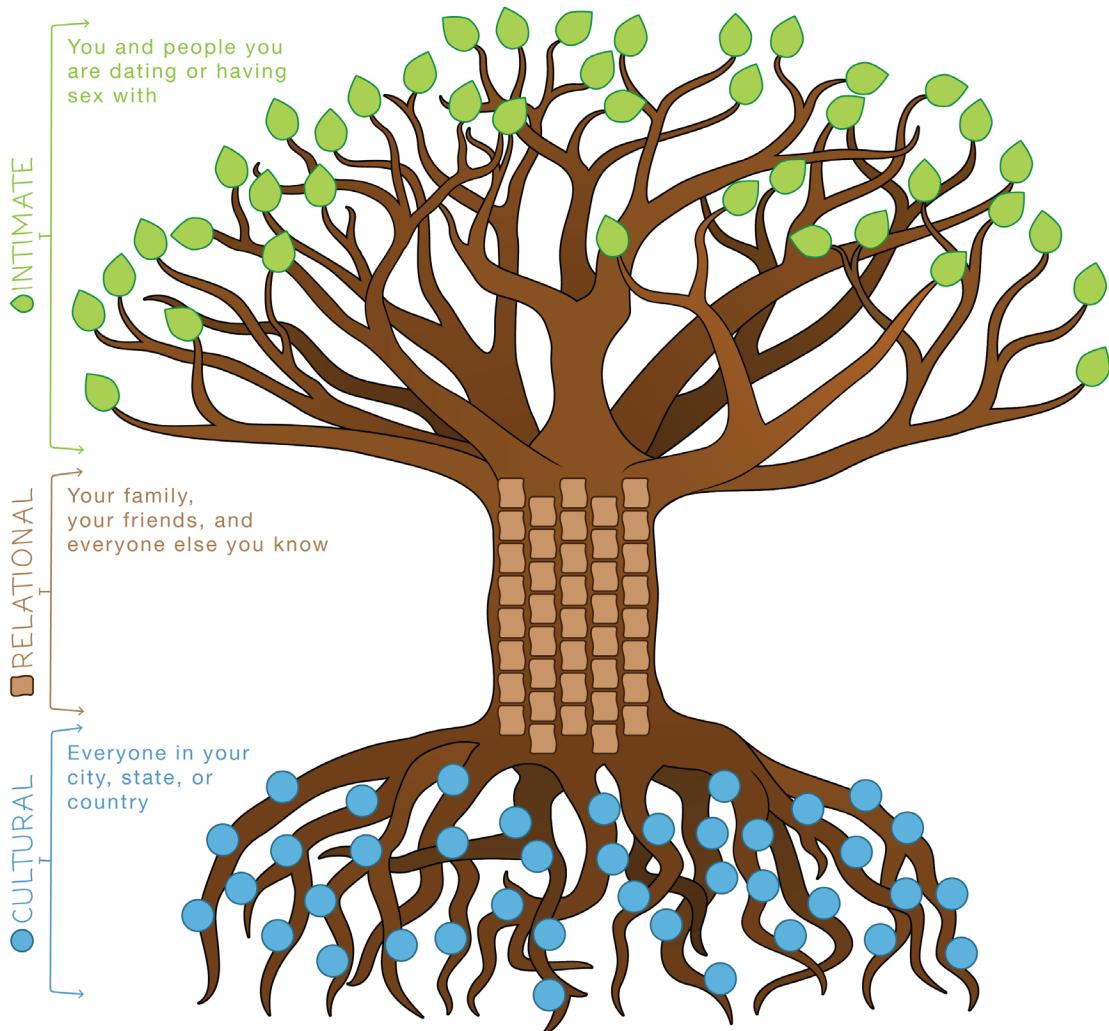
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# THE SEXUALITREE

by UNHUSHED  
Poster v1.0

Hard topics the easy way. Sex ed done right.

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 (●, ■, ○) 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+                        |

What's missing?  
Add your own!



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## **"Sexuality Through the Lifespan" Guide**

This timeline was developed by Dr. Rayne to show the average age that people start to engage in a range of relational or sexual activities. It is critical that these are understood as averages. This means that for people who have these experiences, about half will start to have them before the noted ages and about half after the noted ages. Very few people will start to have all these experiences at the exact listed age.

This handout can be used to address a range of client needs, including parents who are curious and/or concerned about their child's development, and with youth or adults who are concerned or have questions about their own sexual trajectory.

### **A Suggested Introduction**

Introduce this handout with a detailed conversation about statistical averages and what they mean to individuals. Stress that almost no one actually fits the "average" sexual development trajectory. Indeed, there are both pros and cons to engaging sexually in different ways and at different speeds than the average. It is useful to talk with the client about what they think those pros and cons might be—both on a theoretical level and in the client's life.

If you are working with parents, it is important to further stress that the benefit of looking at averages is to consider an entire population. When they are thinking about their child or children, it is important to first consider their own child's individual characteristics, then their child's friends, and only then the average among all of the youth in the United States.

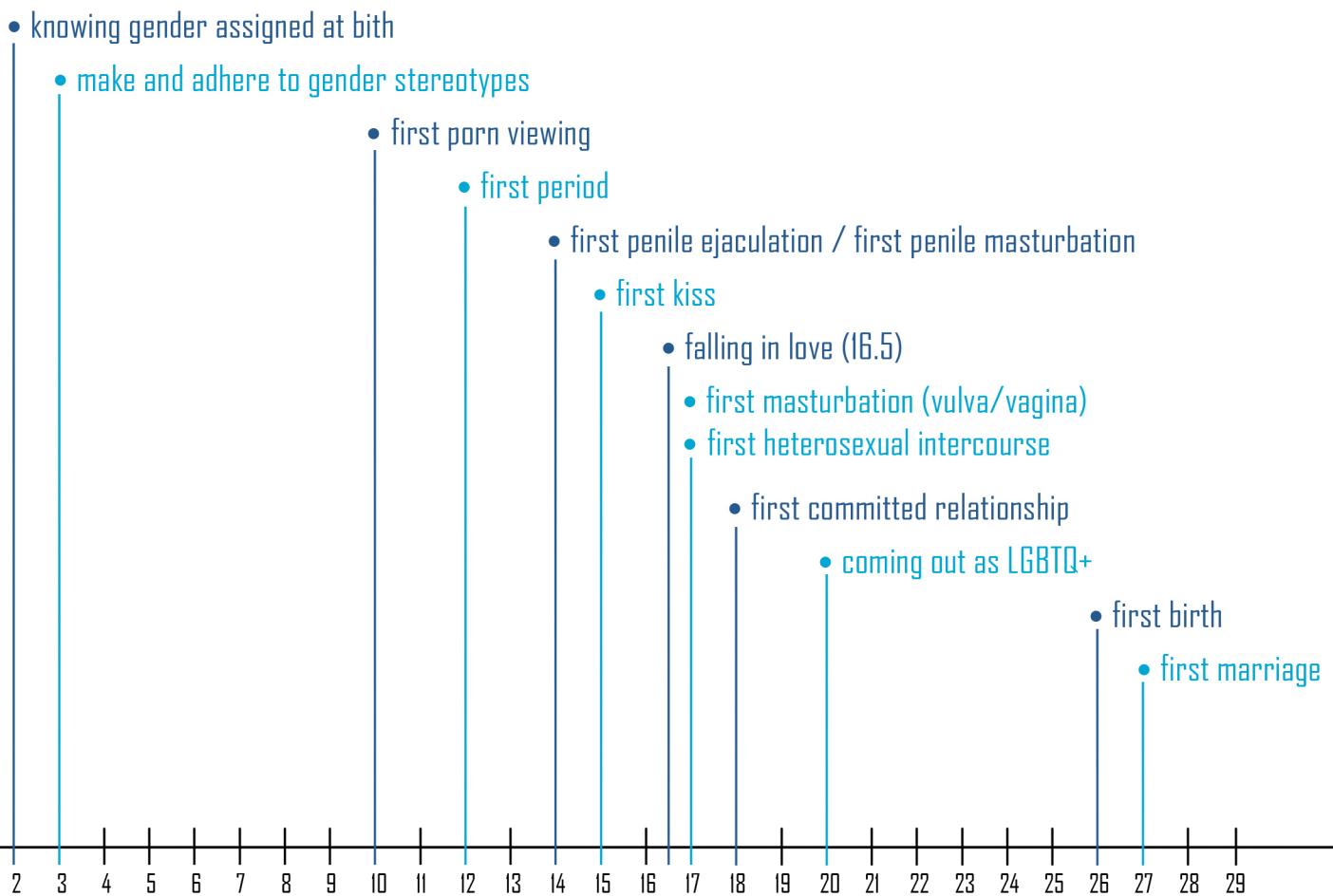
Here are some questions you may ask your client:

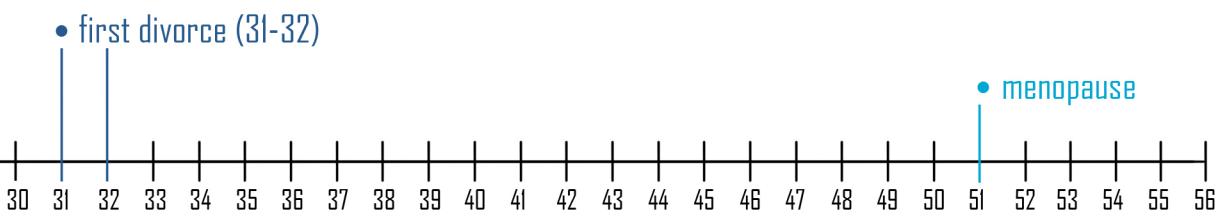
- What might it mean to never do one or more of these relational or sexual activities?
- What is something important for a person to know before they engage in one of these relational or sexual activities?
- Who might a person confide in when they have one of these experiences, and why?

### **A Suggested Wrap-Up**

Process, process, process. This topic can be extremely difficult, especially when someone feels as if they don't "measure up." Have the client think or write about the above questions, maybe between sessions, and then discuss. Allowing the client time to think critically will allow them to work through their thoughts and feelings more effectively.

# Sexuality Through the Lifespan





<sup>a,b</sup>Blakemore (2003). <sup>c</sup>Štulhofer, Buško, and Landripet (2010). <sup>d</sup>Cabrera, Bright, Frane, Blethen, and Lee (2014). <sup>e</sup>Lee, Pabayo, and Kawachi (2016). <sup>f</sup>Robbins, Schick, Reece, Herbenick, Sanders, Dodge, and Fortenberry (2011). <sup>g</sup>Pfizer. (2012). <sup>h,i</sup>Regan, Durvasula, Howell, Ureño, and Rea (2004). <sup>j</sup>Grant (2016). <sup>k</sup>Pew Research Center's Social & Demographic Trends Project (2013). <sup>l</sup>Finer and Philbin (2014). <sup>m,n</sup>Kreider and Ellis (2011). <sup>o</sup>Gold (2011).

## Notes

## “The Social Justice Compass” Guide

The “Social Justice Compass” is a model for looking at, thinking about, and assessing a path for positive social change. This model has three parts: the lanyard, the needle, and the face of the compass, each with a specific purpose. The Social Justice Compass was initially designed by Sam Killermann for UN|HUSHED’s comprehensive sexuality curriculum for high school age students. More information about it can be found on Sam’s website: (<https://www.itspronouncedmetrosexual.com/2019/01/introducing-the-social-justice-compass/>).

Clients may find this model particularly useful if they are social justice-minded, want to effect positive change, and/or interested in how a process of change can occur.

### A Suggested Introduction

Sexuality is deeply embedded in every aspect of culture. It’s related to people’s bodies, identities, relationships, media, and the culture at large, including laws and medicine and beliefs about people’s bodies. Before providing your client with the handout, begin by asking them how they have seen sexuality be impacted in their community. For example: the choices of people they know, pictures in magazines or advertisements they see at the store, school policies, and local laws or political debates. Validate your client’s thoughts and feelings through this process.

Provide the handout to your client and go through the three main concepts together. We suggest starting with the lanyard and the concept of community. The handout does not include in-depth definitions. Those are included below.

**The lanyard** of our compass represents Community. Here we’re defining community as:

- The community of fellow social justice people you are working with, alongside, or in support of, to take steps toward equity; and
- Your local community, or the community in which you’re hoping to effect positive change.

It’s only with a community that we can hold the compass, protecting us from getting lost, making sure we’re always able to look down and clearly see the needle.

**The needle** on the Social Justice Compass represents your current Actions, Attitudes, and/or Beliefs.

- Actions: as anything you’re doing, considering doing, or that is happening;
- Attitudes: as stances, viewpoints, or perspectives; and
- Beliefs: as statements or ideas you (or others) hold to be true.

Any particular action, attitude, or belief, represented in the needle, will point you in a particular

direction.

**On the face** of the compass, we have the cardinal directions of social justice: Equity (our “true north”), Unlearning, Oppression, and Learning. We’re relying on standard definitions for each of these directions:

- Equity: justice for all, the status of social justice being achieved (or inched toward)
- Unlearning: subtracting a particular bit of knowledge or an idea, refining information
- Oppression: injustice (for some, many, or a few), marginalization, subjugation, or structural suppression
- Learning: adding new knowledge or ideas, consuming information

Take your time to talk about each section. Clients may focus on different areas, especially if you are working with groups, couples, or families. Assist the client in processing their thoughts and feelings surrounding the handout and discuss any disagreements the client may have. Disagreeing is a great opportunity for growth.

If you have previously used the Sexualtree handout, included in this manual, with the client the two can be utilized together to think through the client’s past and how it interacts with their journey on the compass.

## A Suggested Wrap-Up

Some clients will connect with this model while others will not, and both reactions are great opportunities for growth and exploration. Here are some helpful questions you may ask:

- What area of The Social Justice Compass stands out the most to you?
- What do you think are some things you need to unlearn and learn to help your needle point more towards equity?
- Do you think using The Social Justice Compass could be of benefit to you, your relationships, and/or family?
- What changes, if any, would you make to The Social Justice Compass?



Legend



From "The Social Justice Compass" by S. Killermann, 2019. Retrieved from <https://www.itspronouncedmetrosexual.com/2019/01/introducing-the-social-justice-compass/>. Uncopyrighted.

## “What Is Sex?” Guide

This tool is easy to use with clients. 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, class, peer group, religion, race, etc. This handout is a simple way to introduce the idea that sex means different things to different people.

### A Suggested Introduction

Begin by saying that lots of people disagree about what *sex* means. Ask your client 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 your client the handout to complete on their own. Let your clients know that there are no wrong answers or judgments for their answers. This is a brainstorming and processing activity for your client, so allow them to explore it in their own way.

If you are working with a couple or a family system, you may give this handout to each person to complete individually and then share their responses with the others. Of course, this activity depends on the couple or family system 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.

Prior to providing this handout to your client is a good time to check in on your personal biases. Understanding beforehand that you will have different opinions from your clients is important.

### A Suggested Wrap-Up

One possible way to end this discussion is with a question like:

- Why do you think people have different definitions of *sex*?
- How did you determine what your definition was?
- How do you think you learned what your definition is?

Discuss the client’s answers and encourage them to think about the activity and to explore their own definition of *sex*. Explain to the client 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?” Guide

This guide is accompanied by three handouts: (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 and romantic orientation, and (3) a blank outline. When introducing the concepts of identity and attraction to a client, always start with the first two handouts.

Clients may find these handouts particularly useful if they are coming to understand their own gender identity and/or sexual and romantic attractions. Identity clarity can happen before, during, or after puberty. For some people, it will happen in adulthood or even during older adulthood. Clients 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 and/or orientation.

### A Suggested Introduction

Knowing who you are takes time; there is no reason to rush the process. However, the media gives mixed signals about what identity and attraction are (as if they are easy to understand and explain) and when someone is “supposed to” understand themselves fully (either before or during adolescence). Many people experience identity and attraction differently than the narrative portrayed in the media.

To account for the real-world difference from the media, before giving your client one of the first two handouts, ask them how they might define the elements of identity and/or attraction listed on the handouts. Validate your client’s thoughts even if they define the ideas differently than the handout does. This conversation is not about being right, it is about identity exploration. Ask your client what they know or understand about the components of identity/attraction.

Provide the handouts to your client and read the definitions together. Take your time to talk about and process what each means. Try to think of examples together. It is likely that the client 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” and “Sexual Orientation Dictionary” handouts, and finally the “Additional Resources” lists. Depending on the age and maturity of your client, you may provide them with some of the resources to read themselves. After they have a solid understanding of the terminology, encourage the client to fill in the spectra, checkboxes, and prompt questions on each of the handouts with information about themselves. *Let the client know that their answers are personal and that they will not have to share their answers with anyone, including you, unless they choose to.*

### Drawing Your Identity

The third handout allows the client to explore their identity via their right brain in a safe environment. This activity can be completed with clients of all ages. You will need to have crayons, colored pencils, or other art supplies available.

Encourage the client to look at the first handout to inform them as they create a visual representation of their identity on the blank outline. They can do this through colors, shapes, words, and anything else that comes to mind. Allow the client time to do this with minimal interruptions. Once the client has completed their identity drawing, invite them to share it with you. If they do not want to, that is also okay. If your client does share, describe what you see in their drawing and thank them for sharing it with you.

Make sure your client 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. Remind them that it is okay for identity to evolve and their descriptions of themselves will change as they and the people around them each learn more about themselves.

### A Suggested Wrap-Up

Whether the client shares or not, here are some helpful questions you may ask:

- Did you learn anything new about yourself through talking about the definitions of these words or how the ideas are organized?
- Will you think about anyone else differently based on a better understanding of gender identity and sexual orientation?
- Did you learn anything new about yourself through the drawing?
- How did you feel while you were drawing your identity?
- How did you feel when you were introducing it?

### Notes

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# What's Your Gender?

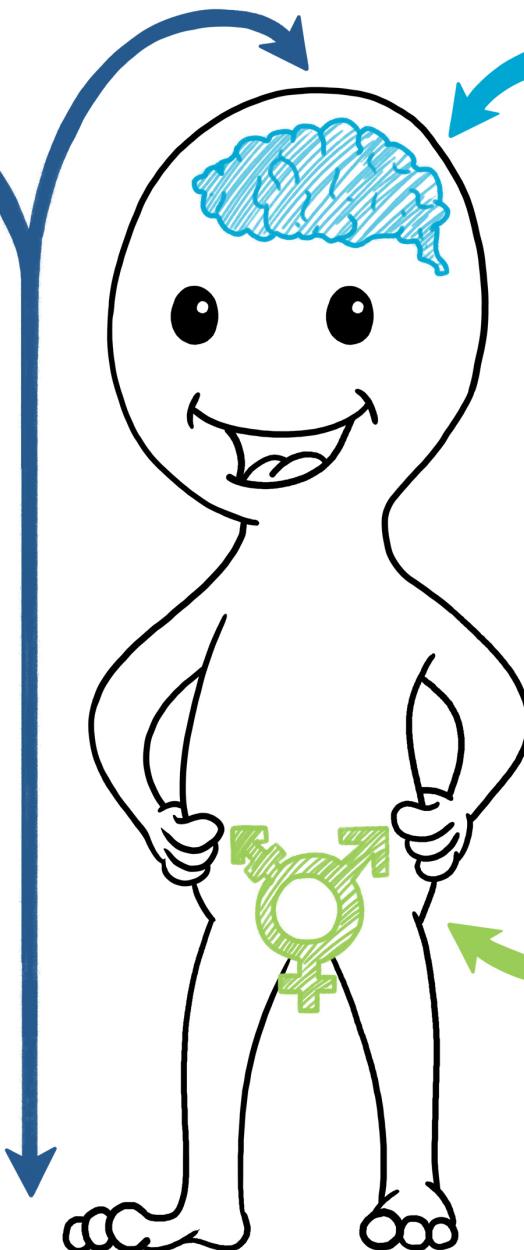
## Expression

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

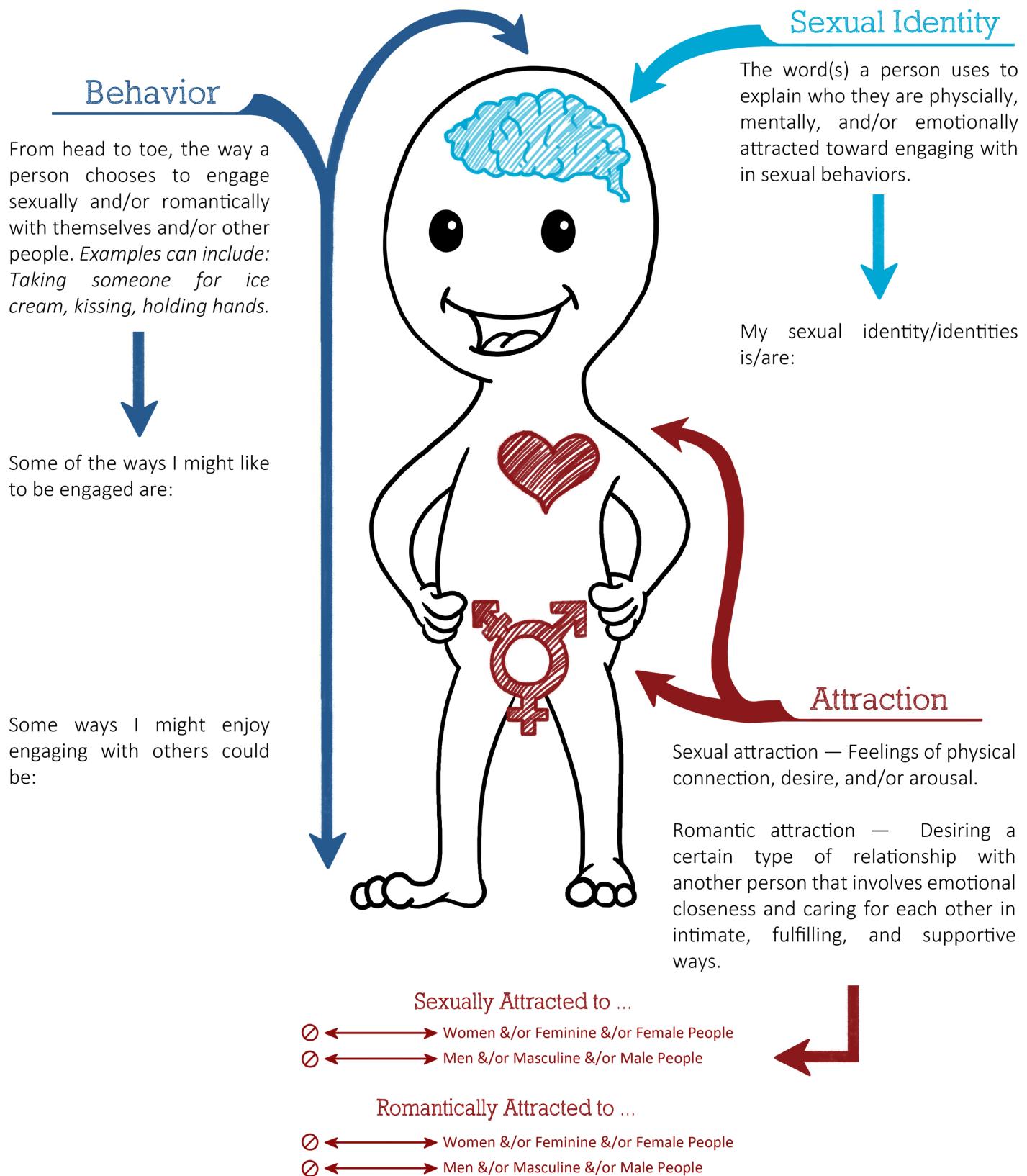
female     intersex     male



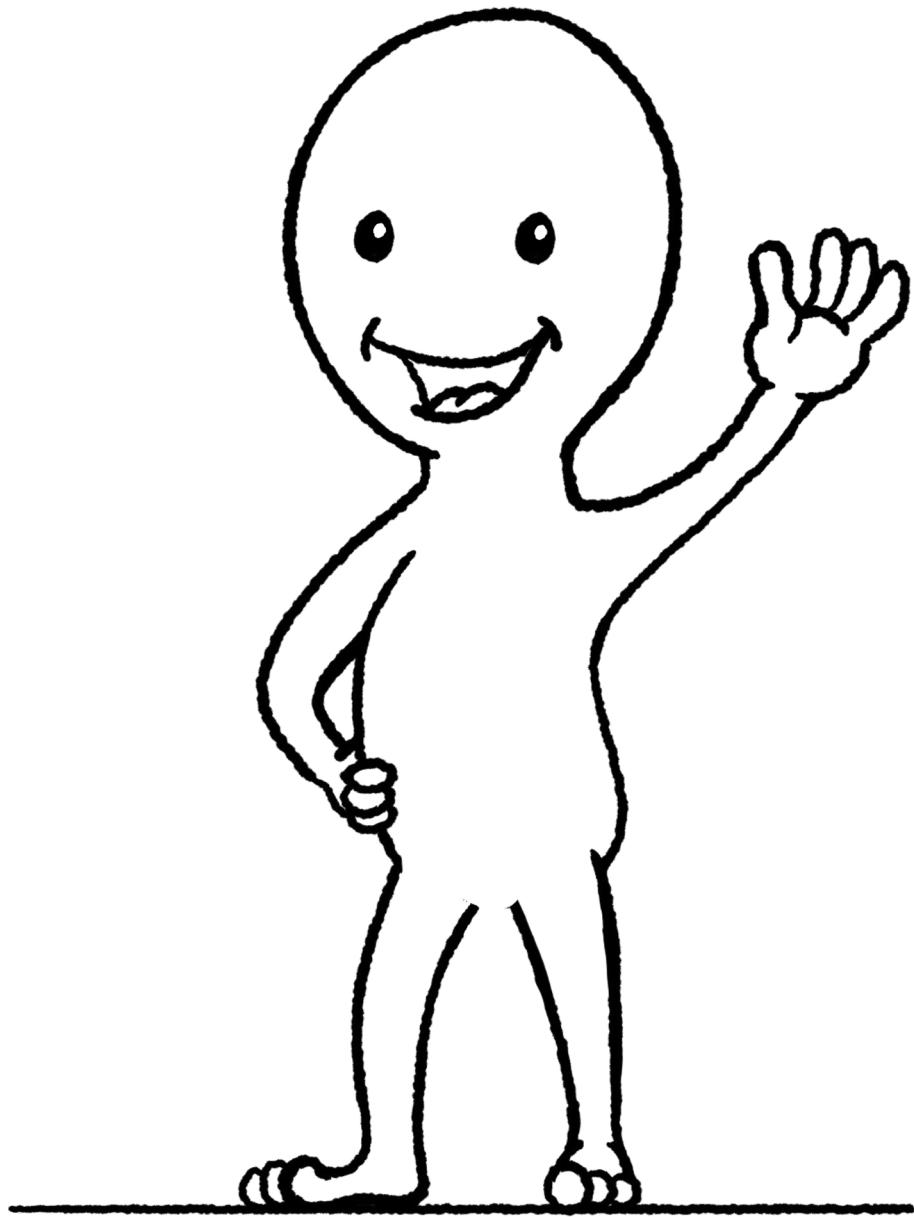
## Anatomical Traits

∅ ←→ female-ness  
∅ ←→ male-ness

# What's Your Sexual Orientation?



## Gender Outline



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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 trainings. You can also find other resource recommendations based on what's included here. If we've missed your favorite resource, let us know about it! Contact us at info@unhushed.org. We may include your idea in the next edition.

### Bodies

Friedler, G. (2008). *Naked Las Vegas*. New York, NY: Norton.

Greg Friedler created a series of city-based images where he photographs a person in their street clothes and then again naked. This is one of the few places to find modern, nude, nonsexual pictures of normal bodies. Looking at them is very supportive of expanding ideas of how bodies are "supposed" to look. In addition to the Las Vegas book, he also has books set in New York, London, and Los Angeles.

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.

### Children's Books

Bergman, S. B. (2012). *The adventures of Tulip, Birthday Wish Fairy*. (n.p.): Flamingo Rampant.

This picture book is written for elementary-school-age kids to 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.

Hall, M. (2015). *Red: A crayon's story*. New York, NY: HarperCollins.

Red 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.

Rayne, K. (2017). *Help your kids with adolescence: A no-nonsense guide to puberty and the teenage years*. New York, NY: 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 9–12 to support their understanding of the incredibly wide range of topics that preteens grapple with. From the Internet to families, from a healthy mind and body to sex and sexuality, this book covers many of the most difficult topics out there.

Silverberg, C. (2015). *Sex is a funny word: A book about bodies, feelings, and YOU*. New York, NY: 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 8–10. It is fast becoming a well-known and loved classic!

## Communication

Perel, E. (2017). *The state of affairs: Rethinking infidelity*. New York, NY: HarperCollins.

Affairs are common and are often perceived as an ending to a relationship, even a long-term, committed, and otherwise happy marriage. Perel suggests that is not the only way. Rather, it is possible to build a new relationship, with the same partner, that is stronger, happier, and has a new understanding of what each person needs. Perel's book is useful for both clinicians and clients.

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.

Westland, G. (2015). *Verbal and non-verbal communication in psychotherapy* (1st ed.). New York: Norton.

This academic book goes beyond the use of tone and asks the reader to look at their body's experiences of communication. Learning more in-depth knowledge about how we as people communicate and the effect that it has on us is important to being an effective mental health practitioner.

## Culture

Danaher, J. (Ed.). (2017). *Robot sex: Social and ethical implications*. Cambridge: Massachusetts Institute of Technology.

Sex with robots is something that, while still on the fringes, will become an increasingly mainstream topic of conversation in the next decade. In what is perhaps the first book to fully engage with the topic, Danaher brings perspectives from philosophy, law, religion, economics, and more to address questions like agency, consent, and love.

Politt, K. (2015). *PRO: Reclaiming abortion rights*. New York, NY: Picador.

In *PRO*, Politt provides a moral and ethical argument in favor of the right to have an abortion. In a culture that remains highly divided on the issue, her voice is strong and clear.

## 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.

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. San Francisco, CA: Cleis Press.

Brill and Pepper go in-depth about transgender children and how families and professionals can support them. Mental health practitioners will find resources, research, 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.

Killermann, S. (2017). *A guide to gender: The social justice advocate's handbook* (2nd ed.). Austin, TX: Impetus Books.

Killermann's writings and graphics on gender have become ubiquitous in the sexuality and gender fields, and for good reason. In this book, he offers people who stand outside of the emerging understanding of gender (including fluid, trans, and nonbinary identities) access to what those and so many other words and concepts mean to individuals who claim them as their own.

TransEquality [Website]. National Center for Transgender Equality. <https://transequality.org/>

National Center for Transgender Equality is the nation's leading social justice advocacy organization for transgender people. Mental health practitioners will find leading research in transgender studies and up-to-date resources in political, health, employment, and more areas.

Transgender Law Center [Website]. Author. <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.

Transveteran [Website]. Transgender American Veterans Association. <http://transveteran.org/>

The Transgender American Veterans Association (TAVA) is dedicated to making sure that all transgender American veterans receive appropriate medical care in accordance with the Veterans Health Administration's Customer Service Standards promise to "treat you with courtesy and dignity . . . as the first-class citizen that you are." Mental health practitioners will find resources including books, policies, and documents.

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

Corinna, H. (2016). *S.E.X.: The all-you-need-to-know sexuality guide to get you through your teens and twenties* (2nd ed.). Boston, MA: 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 (<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.

Rayne, K. (2017). *GIRL: Love, sex, romance, and being you*. Washington, DC: Magination Press.

Written for all self-identified older teen girls, Dr. Rayne's most recent book (before this one) 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*.

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," anyone interested in sex (which, let's be honest, is almost everyone) will find this book a top-choice read.

Yarber, W. L., & Sayad, B. W. (2016). *Human sexuality: Diversity in contemporary America* (9th ed.). New York, NY: McGraw-Hill Education.

The newest edition of this classic textbook lives up to its long history of providing accurate, accessible information about sexuality. Typically used by college students, but a useful reference guide in any professional library, Human Sexuality is a great resource to have handy in the event that surprise topics or questions arise during sessions with clients.

## **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/or 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 stories, rather than 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.

Coontz, S. (2005). *Marriage, a history: How love conquered marriage*. New York, NY: Penguin.

People all over the world can get tied up in knots over what exactly constitutes a “good” marriage and whether they have one. Coontz describes the incredibly diverse ways that marriage has historically been understood (spoiler alert: it’s not always been about love), which supports people’s willingness to accept creative marriage solutions that work for them.

Ryan, C., & Jethá, C. (2010). *Sex at dawn: The prehistoric origins of modern sexuality*. New York, NY: HarperCollins.

Ryan and Jethá break down the common myth that on an anthropological, biological level, men want to have sex and babies with as many women as possible and women want to have just one man who tends to her and her babies. Instead, the authors posit that while we can’t know everything about our anthropological roots, we can be fairly certain that this is not an accurate description of sexuality in prehistory. Rather, modern culture has overlaid on our anthropological ancestors’ assumptions about how we think sexuality “should” work. Breaking apart this assumption can help individuals and couples move beyond a narrow narrative of who they are so that they can more completely be themselves.

## Intersectionality

Emdin, C. (2016). *For white folks who teach in the hood . . . and the rest of y'all too: Reality pedagogy and urban education*. Boston, MA: Beacon Press.

When you work with people whose identities fall outside of the identities you grew up around, it is critical to consider the implications of that disparity. While written for educators, the research, theory, and perspective that Emdin brings is useful to clinicians as well.

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,” which provides a structure for considering cultural differences and how to work professionally across them. Nasserzadeh is an acclaimed sexuality educator and counselor who created the framework so that it is useful in both contexts. Their first Wheel of Context book includes examples and specifics designed to resonate with educators, but their next book may be written for clinicians.

## 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**

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 10 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 access to see what is happening in other homes outside of a highly curated social media presence. This book provides a critical cultural analysis of what got mothers to this place and how mothers can survive the onslaught.

## **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 that people engage in sexual and/or romantic relationships that include more than two people is confusing for many people. This classic has come to be accepted as a must-read for couples who are considering a step toward openness or polyamory and can also support mental health practitioners who are coming to understand this dynamic.

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

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]. Author. <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

Roberts, D. (1998). *Killing the black body: Race, reproduction, and the meaning of liberty*. New York, NY: Pantheon Books.

While decades old, Roberts' powerful voice remains salient and full of meaning. *Killing the Black Body* still educates new readers on old issues while providing a time-specific capture of a critical moment in the reproductive justice movement.

Ross, L., & Solinger, R. (2017). *Reproductive justice: An introduction*. Oakland: 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 from here 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. Mental health practitioners 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.

## Resources Specifically for Mental Health Practitioners

ALGBTIC LGBQQIA Competencies Taskforce, Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H., . . . Lambert, S. (2013). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex and ally individuals. *Journal of LGBT Issues in Counseling*, 7(1), 2–43.

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) is a division of the American Counseling Association (ACA) dedicated to education mental health practitioners on issues faced by the LGBTQ+ community in counseling. ALGBTIC created a competency for mental health practitioners who serve these populations.

Buehler, S. (2016). *What every mental health professional needs to know about sex*. New York, NY: Springer.

This must-read book for all mental health practitioners explores how to work with clients who are experiencing sexuality issues. It provides information on defining sexual issues, new pharmacological treatments, and updates to working with transgender clients.

Hall, S. K., & Graham, C. A. (2013). *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients*. New York, NY: Routledge.

Hall and Graham investigate the intersection of sexuality, relationships, and psychotherapy through the lens of culture. Including case studies and treatment options, and addressing specific sexual problems, this book is a must-have resource for any practitioner who addresses sexuality.

Lipsky, L. V. D., & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. Oakland, CA: Berrett-Koehler.

Written for clinicians and other workers who regularly support people through trauma, Lipsky and Burk's book discusses the idea of mindful presence as the way to maintain a long-term engagement in the face of constant, deep pain. The book includes practices that allows the reader to engage in trauma stewardship and maintain their own mental health.

Singh, A. A., & Dickey, L. M. (2015). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients*. Washington, DC: American Psychological Association.

This clinical guide from the American Psychological Association offers formal, comprehensive information for mental health practitioners who work with transgender and gender nonconforming clients. If you work with or are thinking of working with these populations, then this resource is a must-read.

Weeks, G., Gambescia, N., & Hertlein, K. (2015). *A clinician's guide to systemic sex therapy* (2nd ed.). New York, NY: Routledge.

This book was written with beginning psychotherapists in mind to guide them through the complexities of sex therapy. In this book the reader will find help with accessing sexual behavior, ethical dilemmas, understanding different expressions of sexual behavior, and *DSM-5* diagnosing.

## **Sex and Aging**

Doll, G. (2012). *Sexuality and long-term care*. Baltimore, MD: Health Professions Press.

Understanding the sexual needs of the elderly is a critical component for long-term care facilities, yet often goes unexplored. Doll provides concrete research and support for understanding the sexual needs of older adults whose lives are overwhelmingly controlled by younger people. This workbook supports the facilities in self-examination so that they more holistically support their residents.

Price, J. (2015). *The ultimate guide to sex after fifty: How to maintain—or regain—a spicy, satisfying sex life*. New York, NY: Cleis Press.

Price is one of the most well-known experts on sexuality and older adults; her book provides advice and stories to address the needs of the over-fifty population. She says that “sex changes with aging, but for every problem, there is a solution.” And this is the place to find those solutions.

## **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.

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 included are historical, evolutionary, philosophy, literature, and even sex therapy. The information can support clients both in and out of session.

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.

Kaufman, M., & Silverberg, C. (2007). *The ultimate guide to sex and disability: For all of us who live with disability, chronic pain, and illness.* San Francisco, CA: Cleis Press.

People with physical difficulties are rarely included in the dialogue about sexuality, even while saying that all people are sexual. Kaufman and Silverberg provide voice and support for the people who have been cut out of the dialogue. Including people with a wide range of disabilities, ages, genders, and sexual orientations, this book provides encouragement, support, and concrete tips.

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.

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 they were 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 the 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 that 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 for her guidebook with a series of essays about consent that went deeper and provided a more holistic view of the issue than anything that had come before, Friedman, with Valenti, offered 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 client 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 in sexual orientation where we are growing our learning and understanding the most, and this book provides a primer for anyone who is unsure what that means. Including a thoughtful discussion of what it feels like to be asexual, *The Invisible Orientation* 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]. Author. <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.

HRC [Website]. Human Rights Campaign. <https://www.hrc.org/>

Human Rights Campaign is the nation’s largest civil rights organizations for the LGBTQ+ community. HRC provides up-to-date information on public policy, local issues, and access to health care for LGBTQ+ people. Mental health practitioners will find local, regional, and national resources.

NCLRights [Website]. National Center for Lesbian Rights. <http://www.nclrights.org/>

The National Center for Lesbian Rights (NCLR) is a legal organization dedicated to protecting the rights of LGBTQ+ individuals through litigation, legislation, policy, and public education. Mental health practitioners will find information in over fifteen categories including health care, housing, legal, and sports.

PFLAG [Website]. Author. <https://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. Mental health practitioners will find advocacy work, policy information, and chapter listings for local support groups.

Testa, R. J., Coolhart, D., & Peta, J. (2016). *The gender quest workbook: A guide for teens and young adults exploring gender identity*. Oakland, CA: New Harbinger Publications.

*The Gender Quest Workbook* is a great resource for mental health practitioners with clients who are beginning to develop and explore their identity. This introductory book is full of activities to help the client begin their journey of self-discovery.

## 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 completes her trilogy with a series of chapters that 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 kinds of moral panic around children's understandings of sex and sexuality that cause far more harm than they ever prevent. Levine's perspective can be particularly useful to use with 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 about First Amendment rights as they apply to sexuality broadly and sexually explicit media specifically. His most recent 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 lead to this framework, showing them 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 real? 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 practitioners 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 nevertheless still relevant. They offer a new version of Kinsey's research from the 1950s, expanded to a global scale.



## About the Authors

### **Karen Rayne, PhD, CSE**



Karen's doctoral degree is in educational psychology, which is where she learned to write lesson plans and train educators and facilitators. Since graduating in 2007, she has focused on teaching about sexuality because it allows her to support people's quality of life in dramatic and powerful ways. Karen has written comprehensive sexuality lessons and curriculum for The Center for Sex Education, Girls Inc, the Unitarian Universalist Association, and the United Nations Population Fund. Her recent trade publication books include *Breaking the Hush Factor: Ten Rules for Talking with Teenagers about Sex*, *Help Your Kids with Adolescence: A No-Nonsense Guide to Puberty and the Teenage Years*, and *GIRL: Love, Sex, Romance, and Being You*. Her newest project is building UN|HUSHED into a nonprofit that provides sexuality education curriculum and training to educators, facilitators, and other professionals globally.

When she is not working, Karen is usually traveling or at home in Austin, Texas, baking for her wife and three daughters.

### **Ryan Dillon, LPC**



Ryan is a gay and genderfluid licensed professional counselor who specializes in therapy with youth and young adults, focusing on healthy gender and sexuality development. Ryan is dedicated to serving the Queer community through their private practice and work with nonprofits. Ryan has been a sex educator with UN|HUSHED since 2016 and has also served on the board of various nonprofits including the Central Texas Transgender Health Coalition and The Human Empathy Project. As a narrative and bibliotherapist, Ryan believes in the power of stories to make changes in our lives. To learn more about Ryan and access his substantial and useful reading list, please visit <https://www.theopenbookchat.com/>.