A SEX EDUCATION MANUAL

for the JUVENILE SEX OFFENDER

BY

Elizabeth C. Liberatori

TEACHERS MANUAL
SEX EDUCATION I - TEACHER’S MANUAL

FORMAT: PSYCHOEDUCATIONAL, CLOSED GROUP; 10 SESSIONS OF 90 MINUTES EACH, 1 TIME PER WEEK, REPEATED 3 TIMES PER YEAR.

A COMBINATION OF LECTURES, VIDEO AND AUDIO TAPES, WRITTEN ASSIGNMENTS AND GROUP PROCESS.

PRE-TEST

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Objectives

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Post-Test
SEX EDUCATION I

SECTION I

General Overview of Sexuality

OBJECTIVES:

1. To provide group members with an opportunity to become familiar with the structure and expectations of the Sex Education Curriculum.

2. To allow group members to identify and clarify issues and concerns relating to their expectation of the program.

3. To indicate why learning about our sexuality is important.

4. To develop an atmosphere of respect, trust and honesty.

5. To provide group members with the opportunity to discover that you, as the facilitator, are comfortable with communicating about sexuality.

SESSION ONE

Sex Education Manual and handout folders (double pockets) to include pen and notebook.

Each participant is given a copy of the sex education manual and a folder to carry additional handouts. The facilitator reviews the material, offering illustrations and making clarifications as needed. Participants should be encouraged to ask questions and discuss issues or concerns as they arise.

INTRODUCTION OF GROUP MEMBERS

Each individual is to introduce himself or herself by responding to each of the questions. Facilitator should place emphasis on the participants’ willingness to take risks in sharing their personal experience.

The following questions are written on a board or easel pad:

1. Describe significant relationships you are involved in at present. Facilitator should listen for responses to include relationships that are familiar, friendship, social, other residents, and variations of unhealthy relationships.
2. State first name (ONLY) of your victim(s) and their age(s) at the time you victimized them. Facilitator should watch for noticeable affect of expressions, evidence of guilt and/or shame, evidence of remorse, empathicability to connect with the abuse suffered by the victims.

3. Was your victimizing wrong? Facilitator should listen for responses in the categories of legal, ethical, and value based systems.

4. What do you understand about why you did your victimizing? Facilitator should listen for level of insight expressed by resident.

5. How have you been a victim so far in your life? Facilitator should listen for depth of understanding of resident's own victimization.

ASSIGNMENTS:

Written assignments to be completed and selective questions processed in group for the pages entitled:

WILLINGNESS TO CHANGE
HOW DID YOUR VICTIMS FEEL
HOW HAVE I BEEN HURT BY OTHERS?

SEX EDUCATION
INTRODUCTION/orientation

1. Describe significant relationships involved in at present.
   Families/Friends/Social/Staff.

2. State first name of your victims and their age at the time you victimized them.

3. Why was your victimization wrong?
   Legal/Moral/Ethical

4. What do you understand about why you did your victimizing?
   Listen for level of insight.

5. How have you been a victim so far in your life?
   Listen for depth of understanding.

Listen for issues of:

Ability to connect with persons on a feeling/emotional level
Pair up with a partner. Ask your partner the following questions and then answer your partner’s questions. After 20 minutes the group will rejoin. Then you will introduce your partner by telling the group each of his answers.

1. What is your name?

2. What is your reason for being here?


4. Who was the victim (age, relationship, etc.)? First names only.

5. How did the victim feel?

6. Have you ever been a victim? What happened? How did you feel?

7. Why was it wrong?

8. What do you understand about why you did it?
ASSIGNMENTS:

1. SLANG QUIZ . . .

2. Residents will be expected to read the pages entitled:

"WHERE MEN ARE COMING FROM"
"CRITERIA AND VALUES"
"SEXUALITY -- EVERYBODY HAS IT"

3. Complete the "AM I NORMAL?" quiz before going on to section two.

4. Complete the "MALE-FEMALE" assignment and turn in at the beginning of next group for session two.

5. Break the residents down into teams and give each team an assignment of creating a collage using various forms of media available to them, to include magazines, newspapers, advertisements, written words, etc. The collage should be developed with the general theme relating to how society influences our sexuality and it should involve a variety of specific messages that support the general theme. The team should identify a team representative that will present the collage and all of the input regarding the completion of the collage at the beginning of session two.

SESSION TWO

Have representatives of each team discuss their collage, present the theme, and how other information on the collage supports that theme. Use the general group process to offer feedback and ask questions on further clarification of the information obtained in the collages. Engage residents in general group discussion around the questions of:

"WHAT MYTHS DO I BELIEVE ABOUT SEXUALITY?"
"WHAT ARE THE ADVANTAGES/DISADVANTAGES OF BEING A MALE?"
"WHAT ARE THE ADVANTAGES/DISADVANTAGES OF BEING A FEMALE?"

This discussion should be able to lead into general discussion of "SEXUALITY & IDENTITY-ASSUMPTIONS" and "BELIEFS." Find ways to integrate these into section two in terms of general group discussion for the general theme of social/cultural influences on sexuality.
SECTION II

SOCIAL & CULTURAL INFLUENCES

OBJECTIVES:

1. To provide group members with the understanding that sexuality is an integral part of our personality.

2. To clarify that sexual behavior is only one aspect of our sexuality/intimacy.

3. To emphasize the difference between behavior and worth as a human being.

4. To discuss the commonality of sexual experiences, issues and concerns.

5. To emphasize individual responsibility for attitudes and behavior.

6. To introduce the concept of sexual self-image and provide information regarding developmental factors and their influences.

SESSION ONE

1. Show film entitled "AM I NORMAL?" After film, engage in general processing of film, resident's individual reaction to the film, how they see themselves compared with the main characters in the film, how they see the information in the film relating to the topic of social/cultural influences on sexuality.

2. Show the film "NO EASY ANSWERS" and have the residents engage in general processing about the film, what information they can relate to, what information they can agree/disagree with, how they saw themselves compared to the main characters in the film and what is the most important message they took out of the film.

GROUP EXERCISE:

DEFINE SEXUALITY

Facilitators solicit group participation in developing a definition of sexuality by gathering information through a brainstorming exercise. Write the following on the blackboard:
"SEXUALITY - WHAT IS IT?" Encourage group members to think of as many words or phrases as possible that describe sexuality. Reassure the group that there are no right or wrong answers in brainstorming and that their ideas will not be evaluated or judged.

Encourage participants to be as creative and imaginative as possible. It may be necessary for the facilitators to start the brainstorming process by suggesting a descriptive word or two of their own. After the brainstorming exercise has been completed, the facilitators will present a summary definition of all that sexuality entails by utilizing the group's work and filling in the gaps - "Sexuality is all of the things you have mentioned and..."

GROUP EXERCISE:

LIST ALL THE WAYS PEOPLE LEARN ABOUT SEX

Facilitator is to engage group participation on listing and generally discussing all the various ways that people do, in fact, learn about sex. Part of the discussion needs to entertain how this learning took place, which of the learning was social, which of the learning was cultural, which of the learning was familial, etc.

GROUP EXERCISE:

WHAT DO I NEED TO KNOW ABOUT SOMEONE IN ORDER TO HAVE SEX WITH THEM?

Facilitator needs to engage participants in general group discussion of the topic, specifically making reference to how they can identify and interpret their own individual, cultural, familial influences on the manner in which they answered this question. Also have them discuss how these influences have been present in any previous choices they made with respect to having sex with another individual.

This discussion of the above two questions directly relates to and leads into assignments for this section. As necessary, begin to introduce information from the assignments including:

"WHERE ARE MEN COMING FROM?"
"CRITERIA ON VALUES"
"SEXUALITY - EVERYBODY HAS IT"
3. Introduce "SEXUALITY and IDENTITY" - Assumptions:

Facilitators read each assumption and clarify by offering further explanation or examples. Emphasis is on "knowing" ourselves, identifying our sexuality as a natural and integral part of who we are. Accepting and exercising our right to be informed, recognizing our commonalities relating to issues and concerns, accepting our uniqueness as individuals and personal responsibility for behavior and attitudes. Again, this information will be presented in greater depth throughout the program.

4. Introduce the "SEXUAL SELF-IMAGE" chart:

Facilitators briefly review each of the components, what they entail as well as how they affect our sexual self-image. Each of the components will be discussed in greater detail in future sessions.

- Physiological factors: Biological makeup, physical health (illness and wellness issues), the aging process, etc.
- Social and cultural factors, sex education, values, attitudes and beliefs, prejudices and biases, media, society, religion, peers, family, etc.
- Psychosexual factors: body image, sexual orientation, self-concept, self-esteem, etc.

It is important to emphasize the "connectedness" of all of these factors and influences in the development of our sexual self-image. Emphasis is on our sexuality as an integral part of our personality, self-awareness, importance of healthy sexuality through learning the facts and accepting personal responsibility for attitudes and behavior. Our sexuality is with us from birth to death.

ASSIGNMENTS:

Review the answers to the "SLANG QUIZ" and use it for general framing around how appropriate vs. inappropriate types of communication influence all of the assumptions and beliefs about sexuality.

SUGGESTED ACTIVITIES

TO ACCOMPANY THE SHOWING OF "AM I NORMAL?" OR TO BE USED INDEPENDENTLY IN A UNIT ON MALE PUBERTY.

A MESSAGE TO THE TEACHER
Discussing sex, sexual development, sexual activity can be anxiety producing for teachers as well as the students. Experienced sex educators continue to be subject to occasional blushing, giggling, sudden underarm dampness, blank minds and shock. We accept these things as hazards of the profession and proceed anyway. These reactions are also indicators that we are still human and have not become jaded.

However, a certain degree of comfort in front of a class is helpful. A teacher new to sex education may want to consider the following:

* Take the time to explore your own attitudes about sexuality and your attitudes about the juvenile sex offenders as young men and women who are developing their sexuality.

* Don’t be uneasy about any embarrassment or discomfort you may feel discussing sexuality. Admit it to yourself and to your students and it will be much less likely to get in the way of what you are trying to accomplish with the group.

* Set some sound rules for discussion, for example:
  
  - All questions are acceptable, there is no such thing as a "stupid" question.
  
  - No "put-downs" or "killer statements" will be allowed. For example, "That’s dumb!" or "You did what?"
  
  - Confidentiality will be respected. Questions and discussions which take place in the class will be discussed only in the cottage and in the offenders’ treatment groups. Try to set a contract with the group to this effect.
  
  - No one will be required to talk or share experiences.

Other group rules may be useful, depending on your personal knowledge of the group.

* Try to elicit information from students. Even if it is incorrect, it gives you the opportunity to clear up misconceptions and myths.

* Try to involve parents at some level of your activity.
DISCUSSION QUESTION

TO THE TEACHER:

The following questions to the group may be helpful as discussion starters.

1. What kind of person was:
   Jimmy  Father
   Tony   Librarian
   Barry  Zookeeper
   Susie  Nurse

2. Where else could Jimmy have gone for help? (Mention resources in your school or community).

3. What other things about puberty or growing up could have been included in the film?

4. What are some of the things boys do to impress girls?

5. What are some of the things girls do to impress boys?

6. What are some of the things that are different before and after puberty?

7. What are some of the ways your friends create peer pressure?

8. What sort of pressure comes from radio and TV?

9. What did you learn from this film--something you didn’t know before?
Match the clinical term at the bottom of the page with the slang term.

**Hymen** cherry

**Condom** raincoat

**Vagina** flower vase

**Buttocks** bread

**Oral-Genital Sex** box lunch at the Y

**Condom** man in the boat

**Masturbation** play the organ

**Bisexual** switch hitter

**Masturbation** doing the wash by hand

**STD** dose

**Intercourse** home run

**Vagina** oven

**Penis** dipstick

**Testicles** family

**Menstruation** falling off the roof

**Group Sex** tea party

**Masturbation** priming the pump

**Semen** jazz

**Breasts** oranges

**Penis** hot dog

**Intercourse** making bread

**Bisexual** AC - DC

**Vagina** little beaver

**Semen** mountain dew

**Erection** hard-on

**Oral-Genital Sex** 69

**Group Sex** daisy chain

**Orgasm** heat wave

**Hymen** apple blossom

**Breasts** milk station

**Homosexual** gay

**Oral-Genital Sex** haircut jewels

**Prostitute** tart

**Intercourse** varnishing your cane

**Prostitute** horizontal professional
SECTION III

Psychosexual Factors and Considerations

OBJECTIVES:

1. To discuss and understand the psychosexual factors and considerations that affect individual sexuality.

2. To discuss the developmental aspects and importance of personal attitudes as they relate to sexuality.

3. To emphasize that sexuality is an individual phenomenon, and therefore what is sexually acceptable varies among individuals.

4. To explore personal biases and their origins.

5. To help group members understand the impact of sex stereotyping on their lives.

6. To dispel myths regarding sexual feelings, behaviors, and thoughts.

SESSION ACTIVITIES

1. Refer to the "SEXUAL SELF-IMAGE CHART" used in Section II, Session Two, as a means of introducing some of the influences on psychosexual development.

2. Introduce the concept of gender differences and how gender preferences, beliefs, values, and attitudes have a strong influence on the development of individual sexuality. Reference the assignment "MALE-FEMALE" as a means to allow the resident to consider a manner in which they responded to each of the statements in how their gender preferences influenced their responses.

   Introduce the assignment "AS A MAN, WHY IS IT THAT I:?" and "AS A WOMAN, WHY IS IT THAT I:?" as a means of discussing self-concept from a general perspective.

3. Discuss the "BODY IMAGE EXERCISE." Discuss the various ways in which an individual's body image can have both direct and indirect influences on an individual's sexuality.

   Ask the residents to complete this before the beginning of the next Sex Education I session.

4. Introduce the assignment titled "MALE SEX ROLE
CONDITIONING" discussing the manner in which an individual's psychosexual development and socialization experiences influence attitudes and beliefs about individual sexuality.

5. Discuss the general and specific influences myths have on an individual's sexuality. Discussion can be prompted using the assignments titled:

"SEXUALITY AND HEALTH MYTHS"
"MYTHS AROUND SEXUALITY"

6. Introduce the concept of sexual orientation using Kinsey's Theory of Orientation to describe the continuum of choices available to an individual. If time permits, discussion can ensue around how psychosexual influences and factors surround an individual's sexual orientation.

7. Using the assignment titled "LOVING" introduce group discussion, specifically referencing the three sections. The section titled "RECOGNIZING LOVE" can be used referencing question number two; the section titled "LIVING WITH LOVING" can be used referencing questions two, three, six, and seven; and the section titled "SEXUAL ASPECTS" can be used referencing questions one, four, seven, and eight.

8. Introduce the concept of intimacy using the assignment titled "CIRCLE OF INTIMACY."
Reference should be made to the fact that this is but one model or theory of intimacy and should not be considered as the only one that they can adapt to their individual sexuality. Specific examples /references can be made to the eight dimensions of intimacy using this particular model.

ASSIGNMENTS:

"Ways I can develop intimacy while in treatment." Collect the writing assignments at the beginning of the next Sex Education I Session Two. Divide residents into teams to develop three questions on anatomy/physiology about which they need more information.
SECTION IV

Anatomy and Physiology

OBJECTIVES:

1. To provide basic information and understanding of the anatomy and physiology of both males and females.

2. To provide information about the male and female reproductive systems.

3. To discuss and understand the differences between male and female sexual response cycles.

SESSION ACTIVITIES:

1. Show the film titled "SEXUAL ANATOMY OF A FEMALE" with running time of 14 minutes and 30 seconds. After the film, generally process with the group the following two points:
   a. What information presented was new to you?
   b. What aspects of the film made you feel uncomfortable?

2. Show the film titled "SEXUAL ANATOMY OF THE MALE" with running time of 12 minutes and 30 seconds. After the film, generally process with the group the following two points:
   a. What information presented was new to you?
   b. What aspect of the film made you feel uncomfortable?

3. Show the film titled "SEXUAL PHYSIOLOGY: MALE AND FEMALE" with running time of 14 minutes and 30 seconds. After the film, generally process with the group the following points:
   a. What information presented was new to you?
   b. What aspects of the film made you feel uncomfortable?

4. Present information on the "SEXUAL RESPONSE CYCLE."

   EXCITEMENT PHASE

   Erection of Penis - Early signs of sexual arousal.
Erection occurs as more blood enters the penis and less blood flows out of the penis.

Increase in size during erection is as directly proportional as to the size of the flaccid organ.

Size and firmness of erection often fluctuates markedly during sexual arousal.

**PLATEAU PHASE**

Penis further enlarges--may be color change of corneal ridge.

Phase varies in duration between individuals and between different occasions in the same man.

With premature ejaculation, this phase is often extremely brief.

**ORGASM**

Proceeded in most men by a sense of "ejaculatory inevitability" ("point of no return").

Sexual tension increases to a point beyond which ejaculation is inevitable.

Contraction of prostate gland and seminal vesicles causing emission of seminal fluid into prostatic urethra.

Second phase of ejaculation - expulsion of the seminal fluid along length of urethra and out of urethral opening by rhythmic contraction of the prostate gland, shaft of the penis.

During this stage, the internal sphincter of the bladder is tightly closed to prevent the fluid pouring backwards into the bladder.

**RESOLUTION**

One important difference between this phase in men and the equivalent phase in the female sexual response cycle.

Immediately after ejaculation there is a refractory period during which further ejaculation is impossible.
Period varies from a few minutes to several hours or longer, and increases with age.

Erection is lost in two stages:

1. A rapid partial loss of erection
2. Followed by a slower final detumescence.

5. Present "THE SEXUAL RESPONSE CYCLE" from Masters and Johnson research. Discuss the differences between male and female experiences with the sexual response cycle.

6. Present the information from Charlotte Davis Kasl's book "WOMEN, SEX, AND ADDICTION." Figure 15.1 showing "SEX AS A PHYSIOLOGICAL EXPERIENCE" compared with figure 15.2, titled "SEX AS A LOVING INTIMATE EXPERIENCE." Discuss the differences between these two and entertain discussion as it seems appropriate.

7. Present information regarding "ANALOGOUS TISSUE: UNDIFFERENTIATED" which describes the development of the male and female genitalia while in the fetal condition inside the females womb. Note the similarities of genital areas, with the major difference of male genitalia being external and female genitalia being internal.

8. Discuss female sexual anatomy as a general review and/or, if time permits, discuss female sexual anatomy using the diagram "CUTAWAY OF WOMEN'S INTERNAL GENITALS," the exposed example of the female genitalia, and the display of the "G-Spot" (Grafenberg Spot).

**FEMALE SEXUAL ANATOMY**

**VULVA--EXTERNAL SEX ORGANS:**

**MONS VENERIS** (mons pubis). Area over pubic bone, cushion of fatty tissue, numerous nerve endings, and sensitive to touch or pressure.

**LABIA MAJORA** (outer protective lips). Folds of skin covering a large amount of fat tissue and a thin layer of smooth muscle, mechanical protection for vaginal entrance and urethra.

**LABIA MINORA** (inner protective lips). Curving petals; core of spongy tissue rich in small blood vessels and fat cells; many sensory nerve endings; inner lips meet to form clitoral hood; important source of sexual sensations for most females; nerve endings as sensory receptors.
VESTIBULE - The cleft region enclosed by the labia minora. It houses the opening of the vagina and the urethra.

CLITORIS - A small cylindrical erectile structure at the top of the vestibule and at the lower border of the symphysis pubis. It consists of two crura (leglike stalks) arising at the pubic bone and fusing together to form the body or shaft (like a penis), terminating in the glans, which projects beyond the folds of the labia minora. When sexually stimulated it may enlarge considerably—to twice its flaccid size or more—especially in the diameter of its shaft.

PERINEUM - The area between the thighs, extending from the posterior wall of the vagina to the anus. Often sensitive to touch, pressure, and temperature; source of sexual arousal.

INTERNAL ORGANS:

HYMEN - Opening of vagina covered with thin tissue membrane.

VAGINA - The canal extending from the vulva to the cervix, that receives the penis during coitus (intercourse); a muscular internal organ; lined with a surface similar to the inside of the mouth; source of vaginal lubricators; rich supply of blood vessels and through which an infant passes at birth.

UTERUS - The hollow, pear shaped organ within which the fetus develops; the womb. The inside lining (endometrium) changes during menstrual cycle and bears fertilized egg. The myometrium or muscular wall facilitates labor and delivery; both aspects regulated by hormones.

FALLOPIAN TUBES - The oviduct or egg-conducting tubes that extends from each ovary to the uterus; function of tubes are to pick up eggs and serve as meeting ground for egg and sperm.

OVARIES - Paired structures on each side of the uterus. They produce ova or eggs. Within each ovary are a number of round vesicles called follicles. Each follicle houses an oocyte (an ovum in an early stage of development). At about the seventh month of a female’s fetal life, there are about 7 million follicles in her ovaries. At birth, the vast majority of them have
disintegrated, leaving 200,000 to 400,000 follicles in each ovary. Another function is the manufacturing of hormones called estrogen and progesterone.

9. Discuss male sexual anatomy as a general review and/or if time permits discuss male sexual anatomy using the diagram in figures 2.4 titled "MALE EXTERNAL GENITALS," and figure 2.5 titled "CROSS SECTION OF THE SHAFT OF THE PENIS," and figure 2.6 "MALE INTERNAL GENITALS."

Present the following information.

MALE SEXUAL ANATOMY

MALE EXTERNAL GENITALS:

Penis
Scrotum
Foreskin

I. PENIS - (Shaft)

A. Three cylindrical bodies of exactile tissue:

1. Two top bodies are known as the corpora cavernosa penis, parallel to each other.
2. One corpus spongiosum (houses the urethral canal, which passes through the length of the penis).

B. The end of the corpus spongiosum forms the head of the penis or corona glandis, the rim surrounding the base of the glans penis (the head of the penis).

C. Circumcision - Surgical removal of the foreskin or prepuce of the penis (for religion/culture/hygiene).

D. Average length of non-erect penis is 3 inches to 4 inches. Average length of erect penis is 5 inches to 7 inches.

D. No bones or cartilage--erection results from blood vessels being filled after stimulation.

II. SCROTUM

A. The pouch suspended from the groin that contains the male testicles--responsible for the production of spermatozoa--and their accessory organs.

MALE INTERNAL GENITALS
I. **URETHRA** - The duct through which the urine passes from the bladder and is excreted from the body.

II. **TESTIS**

A. The male sex gland or gonad, which produces spermatozoa.

B. Male sex hormone, testosterone, is produced in the testicles.

III. **EPIDIDYMIS**

A. The network of tiny tubes, approximately 20 ft. long, in the male that connects the testicles with the sperm duct.

B. Maturation chamber for the sperm for up to six weeks, during which time they are nurtured by its lining.

C. The epididymis also serves as a selection chamber. Sperm stops here until ejaculation/breakdown and is absorbed by the system. Sperm will eventually decompose if not ejaculated.

IV. **VAS DEFERENS** (16" TO 18" long).

A. Tubelike structure that conveys spermatozoa from testis to urethra.

B. Carry sperm to prostate and seminal vesicles.

C. Vasectomy is a simple surgical procedure for sterilizing the male involving removal of the vas deferens, or a portion of it.

V. **SEMINAL VESICLES**

A. Two pouches in the male, one on each side of the prostate, behind the bladder, that are attached to and open into the sperm ducts.

B. Produces (about 70%) and secretes a sugar-like fluid (seminal fluid).

C. Seminal fluid ranges in color from white to yellow or gray.

VI. **PROSTATE GLAND** (size of a large chestnut).

A. 30% of seminal fluid
B. Where sperm swim
C. Below the bladder.

VII. **EJACULATORY DUCTS**

A. Space within prostate

B. Sperm, seminal fluid and prostate fluid meet here until ejaculation.

VIII. **COWPER'S GLANDS** - two pea size glands connected to the urethra.

A. Secretes a small amount of mucoid material as part of the seminal fluid at initial point of sexual arousal.

B. Sperm are present in this fluid. This is the reason why birth control by withdrawal is risky and pregnancy is possible without penetration.

C. 1% of semen.

**ASSIGNMENTS:**

Discuss "**MALE REPRODUCTIVE SYSTEM; NAME THE PARTS**" informing residents they need to fill in the blanks with appropriate male reproductive system part. The answers will be given at the start of the next session.

Show the video: "**THE MIRACLE OF BIRTH**."
SESSION V

Boundary Violations & Boundary Setting

OBJECTIVES:

1. To define the concept of "boundaries" in general and begin to concentrate on an individual definition of boundaries for each resident.

2. To identify signs and symptoms of unhealthy boundaries that exist in past relationships or present relationships. Give residents an opportunity to begin to understand how to go about re-establishing new, healthy boundaries.

3. To discuss suggestions and ideas on healthy boundary setting. To develop an understanding of the direct and indirect influences on an individual’s boundaries.

SESSION ACTIVITIES

1. Using the handout entitled "BOUNDARIES," develop a working definition of boundaries. The definition can include either giving examples or soliciting examples of boundaries from residents.

2. Using the handout entitled "SETTING BOUNDARIES," present and discuss the process of setting boundaries. As appropriate, supplement this handout with your own examples or examples you secure from the residents.

3. Using the handout entitled "SIGNS OF UNHEALTHY BOUNDARIES," have residents identify those that have applied to them in the past. Ask them to add to the list any other unhealthy signs that they have been aware of from their own experiences that may not be on the list. Add them to the list.

4. Using the handout "BOUNDARY VIOLATIONS," by providing many additional forms of boundary violations.

5. Using the article from the St. Paul Pioneer Press, discuss the boundary violations contained in that article.

6. Discuss the impact of advertising, sexually explicit materials, R-rated movies, "soft-porn," etc. Discuss the Time Magazine, November 25, 1991, titled "Battling the Bimbo Factor." Engage the residents in some general discussion of other things that they know may have had an influence on some of their own boundary violations.

7. Using the handout "BOUNDARY SETTING EXERCISE," begin the
discussion for the process of challenging the residents to think about and set boundaries that they need for themselves, within the present environment.

ASSIGNMENTS:

1. Have the residents complete the handout entitled "MALE RIGHTS," before the start of the next session.

2. If the present session or the next session permits time wise, engage in a discussion in the above handout in the manner in which the residents respond.
SESSION VI

Sexual Behaviors and The Law

OBJECTIVES:

1. To provide a framework for discussing and understanding sexual behavior within the context of legal, moral, and societal issues.

2. To explore the question "What is normal sex?"

3. To present and discuss a framework of standards for sexual behavior.

4. To define and discuss the concepts of mutuality and consentuality with respect to sexual behavior.

5. To provide and discuss a framework for categorizing and understanding the various types of abuse.

SESSION ACTIVITIES:

1. Begin the session by involving the group in general discussion around the question of "HOW DO WE LEARN ABOUT SEXUAL BEHAVIOR?" Using the board or easel pad, list the various ways that are identified. Have the residents write them in their notebook.

2. Based on the things written on the board or easel pad, introduce the concept of the "NO TALK RULE" and ask the group members how this rule affected/influenced their perceptions, understanding, and attitudes about sexual behavior.

3. Use the information garnered from items one and two (above) in the discussion of normal sexual behavior. Using the board or easel pad, write the question "WHAT IS NORMAL SEX?" and involve group in discussion of this question. The goal is to allow the group to see that what is normal to one person may be very bizarre to the next. Individual differences notwithstanding, however, there are standards in any society that determine acceptable behavior.

All societies regulate behavior, including the sexual behavior of its members. There are some sexual behaviors that many societies find totally unacceptable, deeming them repugnant. For example, in the United States, incest is against the law in every state. This does not mean, however, that everyone abides by the same set of laws and standards.
4. Introduce the concept of "STANDARDS OF SEXUAL BEHAVIOR" to determine normalcy. Of course, not everyone agrees on which standard is the most important or is applicable in a particular case. The decision to site a norm depends not only on the person but also on the general and particular circumstance.

5. Discuss the "STANDARDS OF SEXUAL BEHAVIOR" to include:

A. Statistical--What most people do;
B. Religious--What one's religion permits or prohibits;
C. Cultural--What one's culture encourages or discourages;
D. Subjective--How a person judges his or her own behavior.

If more than half the people in a sample commit or perform some act, this norm could validate normalcy for that group of people. For example, it may be that in the United States today, more than 50% of all one stashes of married persons have ended a marriage in divorce. Is it normal to be divorced? If one uses only the statistical standard, then it is indeed normal. Another example; if more than 50% of males masturbate, then is masturbation normal? Using only statistical standards can be dangerous because it can make law breaking appear "normal." For instance, many teenage boys will involve themselves in shoplifting. Does this mean that it is normal to steal?

Religion plays a very important role in many people's lives. It determines the rightness or wrongness of their behavior. In matters of sex it may play a pivotal role as it determines the acceptability of certain acts.

In every society, there are cultural rules, including sets of words, ideas, customs, and beliefs. For example, in American society, it is against the law for a person to have more than one spouse at a time. Culture and normatives structure a society. There can be no society without rules; there can be no society without culture. Our culture attempts to regulate, in some fashion, sexual behavior. Pedophilia, incest, rape, lust, murder, exhibitionism, and other sexually aberrant behaviors that are viewed negatively by the majority of American citizens are against the rules in our society.

The subjective standard is perhaps the most important standard in a person's life. This standard legitimizes behavior in the same fashion as the statistical, religious, and cultural standards, but at a personal level. For example, the last time you drove slightly above the speed
limit on an interstate highway, chances are there were many drivers passing you as you drove along. Even though you were violating the speed limit, others were doing the same thing. You may have rationalized your own law breaking by saying, "they were driving much faster than I was." It is not simply enough to legitimize behavior that may be judged deviant or aberrant by some other members of a society; we must feel that what we are doing is not only normal, but we cannot feel bad about our behaviors. This last standard is the most important.

6. Involve the group in a discussion of defining the term "MUTUAL" as it relates to sexual behavior.

7. Involve the group in a discussion of defining the term "CONSENSUAL" as it relates to sexual behavior.

8. Using the concepts of "MUTUAL" and "CONSENSUAL," involve the group in general discussion of appropriate vs. inappropriate sexual behaviors. Both mutual and consensual.

9. Discuss the differences between legal issues and moral issues as they relate to individual sexual behavior. Ask the group to provide examples of both appropriate and inappropriate examples of this behavior they have engaged in in the past.

10. Using the handout "TYPES OF ABUSE," discuss the various categories of abuse listed on the handout. Ask the group to provide examples of the types of abuse that they are willing to admit having experienced, either as a victim or as a perpetrator. This discussion can involve the use of both overt and covert seduction; elements of power, force or threats; and types of manipulation used.

11. Using the handout "SEXUAL ABUSE DEFINITIONS," highlight the key points under each of the definitions.

ASSIGNMENTS:

1. Divide the residents into groups and have each group prepare a chart differentiating appropriate vs. inappropriate sexual behaviors. The chart needs to contain information identifying which of the behaviors were against the four previously discussed standards, against the law or against an individual's moral beliefs. The chart should also identify which types of abuse categorizes the inappropriate sexual behaviors.
SECTION VII

AIDS--Autoimmune Deficiency Syndrome

* 8-10 million adults carry the virus that leads to AIDS.
* By the year 2000, 40 million adults and children will have HIV.
* 5000 people per day are infected with AIDS.
* 31,196 died in 1990 from AIDS.
* Center for Disease Control estimates 215,000 people may die within the next three years.
* This represents an approximate 700% increase since 1990.
* 85% of those infected before 1986 have already died.
* Actual case-fatality ratio approaches 100% within five years after the diagnosis of AIDS.


-- Heterosexuals 6%
-- Male Homosexuals 52%
-- IV Drug Users 24%
-- Male Homosexual
  Drug Users 7%
-- Others 9%

STAGES OF AIDS
Stage 0: Exposure to HIV.
Stage 1: Symptoms of an acute infection by HIV.
Stage 2: Chronic Lymphadenopathy (swollen lymph glands).
Stage 3: T4 cell depletion.
Stage 4: Clinical evidence of suppressed immunity.
Stage 5: Infection of the skin and mucous membranes.
Stage 6: Opportunistic infections (recurrent and prolonged illnesses).

AIDS & THE HETEROSEXUAL

Aids, The Disease

"Autoimmune Deficiency" simply means, in laymen's terms, a disease that weakens and then destroys the body's ability to fight off infectious organisms. "Syndrome" refers to a particular pattern of illnesses associated with the disease.
The Center for Disease Control (CDC) reports that the actual case-fatality ratio approaches 100% within 5 years after diagnosis of AIDS. This grim statistical measure states that once "clinical" AIDS is diagnosed, the vast majority of patients will die within 5 years. A patient is said to have developed "clinical" AIDS when he or she shows severe signs of depressed immune functions and begins to exhibit opportunistic infections.

HOW AIDS KILL

HIV cripples the immune system by directly infecting and killing the T cells, a key component in the body's defense against infections. T cells are one of the many different types of white blood cells found in the body.

Like other viral infections, HIV leaves behind a telltale signature when it infects a person--the appearance of antibodies. Antibodies are protein substances found in the blood, which the body produces to help fight invading organisms.

For some reason, which is unknown at the present time, the production of antibodies after HIV infection is not sufficient to prevent disease from progressing further. The presence of antibodies against HIV does, however, indicate infection. The antibodies can be detected by a blood test, and if these antibodies are present the person is said to be seropositive for HIV. By CDC's criteria, a person who is seropositive but asymptomatic (without any clinical symptoms), does not have AIDS. Only when the person develops clinical symptoms associated with AIDS, such as opportunistic infections, can a person be diagnosed as having AIDS. Thus, a person who becomes infected by HIV is seropositive but does not actually have AIDS, only the potential to develop the disease.

Once the person exhibits clinical symptoms of a depressed immune system, then the person now has "clinical" AIDS. This is a very important distinction, both for the person infected with HIV and the clinician. For the patient, this is a crucial turning point in the disease process which will likely result in a rapidly fatal outcome within 5 years. To the physician, the patient is diagnosed as having AIDS, and the case is reported to CDC. Another AIDS case then goes on record.

Therefore, merely being infected with HIV does not classify the person as having AIDS, only that he or she is seropositive for HIV. Infection by HIV will likely lead to death. The key word is "likely". The AIDS epidemic is so recent, and the disease process is so painstakingly long, that researchers are not certain if every person who has been infected with HIV will develop AIDS and die. Studies of homosexual men in San Francisco suggest the 54% of those infected will develop AIDS within 10 years and up to 99% will eventually die.
Slow Agonizing Road to Death

Stage 0: Exposure to HIV

Compared to other viral diseases, the lag time between infection by HIV and development of the clinical symptoms is much longer. After the initial exposure to HIV, there may not be any sign of illness for many days, or even weeks. The range is 3-8 weeks. The delay time between exposure and development of symptoms is technically known as the "eclipse" period.

Stage 1: Symptoms of an Acute Infection by HIV

In some people the first sign of an infection after the initial exposure is an acute mononucleosis-like illness, which can occur about two weeks after the infection.

In any case, the symptoms disappear within a few weeks. All immune functions are normal at this point.

It is usually during this stage of infection that the first clinical evidence of HIV infection is detected. A clinical blood test, called an ELISA (Enzyme Linked ImmunoabSorbant Assay), reveals the existence of antibodies against HIV. The person is said to be seropositive. If the ELISA test is positive, the results are usually confirmed with another procedure called a Western Blt Analysis, which is a more specific test for antibodies against HIV.

The time when an infected person seroconverts (becomes seropositive) after the initial exposure to HIV, has been one of the most difficult factors to evaluate. However, the vast majority of infected individuals seroconvert within four to sixteen weeks after exposure. Admittedly, the absence of a seroconversion after infection is a very rare phenomenon, but it does exist.

Stage 2: Chronic Lymphadenopathy (swollen lymph glands)

Following seroconversion, the next clinical sign of HIV infection is usually the appearance of persistently swollen lymph nodes. In most persons infected with HIV, this stage marks the first indication that is something very wrong with the immune system.

This clinical feature can persist for many years, but usually lasts from three to five years. Throughout this stage of the infection the patient may feel fine, without demonstrating any additional symptoms. But highly sensitive tests of cellular immune functions reveal abnormalities in the activities of white blood cells, T cells in particular. During this period there is
also a very gradual, but persistent decline in the T4 cell count in the patient. T4 cells are a sub-population of T cells which is the most critical of the body's defense system against infection. The drop in T4 cell number indicates that HIV is slowly, but surely, killing off more and more of these crucial cells.

**Stage 3: T4 Cell Depletion**

When the T4 cell count in the patient's blood sample drops below 400, he or she enters stage 3. This stage usually lasts for 18 months.

**Stage 4: Clinical Evidence of Suppressed Immunity**

This stage is entered when the patient fails to show "delayed hypersensitivity," which is a measure of immune function.

**Stage 5: Infections of the Skin and Mucous Membrane**

At this stage fungal and viral infections begin to appear on the mucous membranes. The immune system is on the verge of complete breakdown.

**Stage 6: Opportunistic Infections**

The development of infection usually occurs a year or two after the patient enters stage 5. This signals a severe, life threatening loss of cellular immunity. The T cell count can drop below one hundred. Infections of many types are rapidly disseminated throughout the body and spread to all the major organs. Until recently, most patients died within two years of diagnosed opportunistic infections. But with the advent of azidothymidine (AZT) therapy, and treatment of other viral and bacterial infections with newer drugs, the survival of AIDS patients has been significantly enhanced.

CDC regards patients who are seropositive for HIV in stages 2 and 3 as having "pre-AIDS," while those in 4, 5, or 6 have "clinical AIDS." People infected with HIV may remain in stages 2 and 3 for as long as 4-5 years after initiation of the infection.

**People Who are Seropositive**

According to the Public Health Service, between 1 to 1.5 million people are infected with HIV in the United States. We are in an AIDS epidemic, but only in the early stages. The epidemic has only recently occurred in the United States.

A person who is seropositive is considered to be infectious. He or she is able to transmit the virus to their uninfected sexual partners. The person is presumed to be infectious for the rest
of his or her life.

The time between HIV infection and development of clinical AIDS is known as the incubation period.

85% of those infected before 1986 (during the early 1980’s) have already died of AIDS.

HOW THE AIDS VIRUS IS TRANSMITTED

Scientific evidence has overwhelmingly demonstrated that HIV cannot be transmitted through casual contact. Simply defined, casual contact is a behavior one would use in their day to day activities with other people, one which precludes intimate contact.

In studies involving over 500 family members, no member was found to ever be infected through casual contact with an AIDS patient.

Others studies have indicated that HIV cannot be transmitted by:

1. Animals
2. Blood Donation: If a sterile needle is used during the blood donation procedure there is absolutely no risk in getting infected with HIV. In the United States, only sterile needles are used on donors who give blood.
3. Food and Inanimate Objects: It does not infect animals, so the virus is absent in dairy products, meat or poultry products. HIV cannot survive and be transmitted on counter tops, toilet seats, drinking fountains, plates, glasses, eating utensils, or any other item which could be shared by individuals in their day to day activities.
4. HIV cannot be transmitted by biting insects.

The Gray Area: Kissing & "Smooshing"

Infection by HIV through direct contact with saliva only, as in kissing, has never been documented. There is no case on record to indicate a possible transmission mode by saliva. Heavy and deep kissing (French kissing) for long periods of time can lead to the exchange of significant amounts of saliva between partners. In this context, it should be noted that recommendations by CDC explicitly warn against "any exchange of bodily fluids."

CDC states further that "toothbrushes, razors, or other items that could be contaminated with blood" should not be shared between infected and non-infected persons.

In terms of transmission, however, most of the evidence suggests
that infection through exposure to saliva alone is extremely low.

However, passionate kissing, such as the prolonged open mouthed kissing between lovers, which usually involves vigorous rubbing of the oral mucosal (lining of the oral cavity) by both partners, could presumably increase the risk.

If one of the persons is seropositive, the risk is increased even if the patient is asymptomatic (without clinical symptoms).

**Major Routes of HIV Transmission**

Almost every case of AIDS has been linked to just three clearly recognized modes of transmission:

1. Sexual Intercourse.
2. Injections of Blood (intravenous needle sharing, transfusions).
3. Perinatal (mother to fetus).

**HIV INFECTIONS AMONG HETEROSEXUALS**

As of April (1990), the total number of AIDS cases has been 132,510. Of these, women comprised of 13,268 cases (10%).

**CAN YOU DECREASE YOUR CHANCES OF BECOMING INFECTED?**

"High-risk" and "Low-risk" Individuals

CDC has established a certain set of criteria which group individuals into a "high-risk" population:

- **Group 1.** Male homosexual or bisexual.
- **Group 2.** Intravenous drug user.
- **Group 3.** Hemophiliacs or recipients of blood or other blood components or individuals with a history of multiple blood transfusions.
- **Group 4.** Individuals who have resided in Haiti, Central Africa, or in a country where heterosexual contact is the main mode of transmission.
- **Group 5.** Sexual contact since 1978 with any person who belongs in the above risk group.
- **Group 6.** Sexual contact with an HIV-Seropositive individual.

**Role of Gender in Transmission of HIV**

The other subject which needs clarification is the relationship of gender to the transmission dynamics of HIV. Is the ease of transmission dependent upon whether the infected person is a man
or a woman? Many people still think it is more dangerous to have a sexual partner who is an infected man than an infected woman. In truth, any infected person can transmit HIV. Whether a person is male or female makes no difference. Your chances of getting AIDS is the same regardless of the sex of your partner.

Contrary to what you might suspect, the spread of HIV infection is greatest, not only in a population of individuals who are highly promiscuous, but also in ordinary people without a large number of sexual partners.

**Infectiousness of a Seropositive Person**

What are the chances of getting infected by having sex with a person who is seropositive for HIV? The chances of you being infected by someone who is seropositive will depend largely on two things, how infectious the person might be in transmitting HIV, and the practice of sexual behaviors that might put you at risk for infection. Of the two, sexual practices have the most influence.

**Important Facts About HIV Infection**

**Frequency of Sexual Contacts**—Another variable in the transmission of HIV is the frequency of sex with the infected individual. Many people cannot or will not believe that HIV infection can occur through casual sex, more commonly known as the "one night stand."

In one case study, five out of eight women who admitted only "casual sex" with the same man with AIDS became infected.

**Anal Intercourse**—Among heterosexual couples, vaginal intercourse has been shown to be the major transmission route of HIV. It does not matter whether the infected partner is a man or a woman, infection of the susceptible partner will occur sooner or later if no condoms are used.

More recent surveys involving large numbers of heterosexual men and women have indicated a high percentage (up to 50%) of college-aged adults engaging in anal intercourse. Although only about 10% of those surveyed indulged in this practice regularly, very few of the people interviewed reported any use of condoms. In the teenage population as well, the percentage of adolescents practicing anal intercourse was 10-12%, and condoms were used very rarely. If one is to participate in anal intercourse, then the best protection against infection is for the insertive partner to use a condom. However, much more care is necessary, even when the devise is used, to ensure adequate protection because condoms are much more likely to tear or break with this type of behavior, as compared to vaginal intercourse. Even under ideal circumstances, anal intercourse is considered to be much
riskier than vaginal intercourse.

Oral Sex: Questions concerning the risks associated with HIV infection through the practice of oral sex have come up again and again. Complete resolution of this issue remains problematic because no clear data have been identified to determine the type or degree of risk involved. However, in the absence of any clear and defined evidence of danger, most clinicians would designate the risk of oral sex as minimal, if any.

PROTECTING YOURSELF AGAINST INFECTION

The number of AIDS cases attributed to heterosexual activity was 3,962 (as of March, 1989), from a total of 890,501 AIDS cases reported to CDC. This is roughly 4% of all cases.

The percentage of cases acquired as a result of heterosexual contact has been slowly rising since 1985 (3-4%) to a level of almost 5% in 1990. It will reach 10% sometime during this decade.

The Tools of Protection

The suggestion by Hearst and Hully that people become more knowledgeable about their sexual partner's past life is highly recommended, even by the study's most vocal critics.

Are Condoms the Answer?

When confronting a situation involving sex with too many unknowns, the best protection is the "latex" protection, CONDOMS!

As effective as condoms are in theory, in practice they are never 100% effective. There are many reasons for this. Improper and/or inconsistent use reduces effectiveness, so does mechanical failure. Breakage or tearing can occur in many instances, especially when the condom is used during anal intercourse. There is always a compromise between making the condom thick enough to withstand the physical stresses associated with sexual intercourse, and thin enough so that user sensitivity is not adversely affected.

Hearst and Hully quote a failure rate of condoms, when used as a preventive measure against pregnancy, at about 10% per year (one out of every ten instances). Condoms have been used successfully in preventing the transmission of sexually transmitted diseases. Their use in preventing infection by HIV has been well documented, and the evidence so far indicates that condom use can dramatically reduce the spread of infection.
The "Ins and Outs" of Condoms

Some interesting facts about the "latex policemen." First of all, the thickness of a standard latex condom is very thin, less than 1/1000th of an inch. This is much thinner than a sterile surgical glove (which is 6 times thicker).

There are basically two kinds of condoms, one made of synthetic latex and the other from natural membranes, such as lambskin. Incidentally, most natural membrane condoms made in the United States consist of material from the intestine of lambs imported from New Zealand. The difference in sensitivity between the two types is probably more of a subjective, rather than an objective opinion. Laboratory tests have revealed that while all latex condoms which have passed vigorous tests did provide an effective barrier, those condoms made from natural membranes consistently demonstrated leakage of HIV and other viral agents across the surface of the membrane. Consequently, many clinicians recommend using only latex condoms for sexual intercourse with persons at a high-risk for HIV.

The testing program began in 1987. Since then the FDA has tested 102,000 samples from 430 batches of domestic and foreign made condoms. More than 99% of the condoms used in the United States are made domestically. Approximately 12% of the domestic, and 21% of the foreign made condoms failed the test.

Studies on the use of condoms and their effectiveness as a contraceptive to prevent pregnancy have indicated a varying rate of between 64% to 97%.

Explicit instructions on how to properly use are usually provided by package inserts, or notes written directly on the package containing the condom. To maximize its preventive role, the condom should be put on before any genital contact with your partner. Improper lubrication is the main culprit for breakage of a latex condom. Some condoms are pre-lubricated. If lubrication is needed, then use only water-based lubricants, contraceptive foams, jellies, or creams. These are available over the counter in any drug store, and the product is clearly labeled for its specific use with condoms.

Never use petroleum or oil-based lubricants such as petroleum jelly, cooking oils and shortening, or hand lotions. These will inevitably weaken the latex material and cause breakage. As a last resort, water may be used as a lubricant.

Consistent use of the condom is mandatory for preventing infection. The use of a latex condom is preferred over one made with a natural membrane such as lambskin. Excessive heat, and especially direct sunlight, can weaken or damage condoms. Consequently, they should be stored in a cool, dark place. Do
not store condoms for a prolonged period of time (e.g. a day or more) in your wallet.

If the package containing the condom is damaged, or if the condom shows signs of age, such as being excessively brittle, sticky or discolored, then it is not advisable to use them.

Recently, condom manufacturers have developed new "extra-strength" condoms because of the AIDS crisis. The extra-strength condoms were actually found to be stronger than the ordinary ones, but the "strength" varied from brand to brand.

In actual practice the extra-strength condoms would probably resist failure better than ordinary condoms. But how much extra protection the new condoms really provide has not been carefully determined.

Research is presently in process to develop a female condom. Female condoms have been shown to be effective in preventing infection by venereal diseases. The protection afforded by this new type of condom was, in fact, much better than commercially available male condoms.

Teenagers and AIDS

The most sexually active individuals fall within the age group of 17 to 25 years old. Most patients dying of AIDS today are young, mostly between 25 to 40. The majority of these patients were infected while even younger, five to ten years ago. This is the age group that will be the hardest hit by the epidemic for many years to come.

It is estimated that by the age of 14 almost 50% of the female teenagers in the United States have experienced sexual intercourse. For boys of the same age, the percentages are 46% for Caucasians, 65% for Hispanics, and 85% for Blacks. Because of the increased sexual activity among teenagers, sexually transmitted diseases have reached epidemic proportions. Gonorrhea has been found in teens as young as 10 years of age.

The next generation of persons who will have AIDS are now being infected as teenagers. High risk endeavors such as experimentation with drugs, as well as sex, make teens likely candidates for infection. This is nowhere more evident than in New York City, where 20% of all AIDS cases (one in every five) occur in persons between the ages of 13 and 21.

The youngest AIDS patient attributed to heterosexual contact was 13 years of age. The number of AIDS cases among people in their 20's in 1989 increased 40%. Yet many who were sexually active (greater than 50% of the students surveyed) with multiple partners did not use condoms.
The Future of AIDS

In the United States there was a 36% increase in heterosexually transmitted AIDS cases from 1988 to 1989. This ranks with the 38% increase observed with perinatally transmitted HIV as the fastest growing category of transmission.
SECTION VIII

Comparison of Shame & Sexual Shame

OBJECTIVES:

1. Define shame, sexual shame and guilt. Discuss the differences between them.

2. Discuss the formation of shame and sexual shame.

3. Discuss the cycle of shame and sexual shame.

4. Discuss strategies for shame reduction/resolution.

SESSION ONE:

1. Using some general relaxation techniques and guided imagery, create a visualization, take them back to their very first childhood experience when they can identify experiencing shame and their very first childhood experience when they can identify experiencing sexual shame. Do these as two separate and distinct exercises. From the experiences and the discussion, the facilitator should be able to begin to point out how the experiences are different.

2. Introduce the definition/explanation for shame and guilt, from, FACING SHAME, by Fossum & Mason and sexual shame from CONTRARY TO LOVE, by Carnes.

3. Using the handout entitled "SHAME" present the qualities/characteristics of shame.

4. Using the handout entitled "GUILT" present the qualities/characteristics of guilt.

5. Using the handout entitled "A COMPARISON OF SHAME AND GUILT" discuss the similarities and differences. Using the blackboard or easel pad, have the group develop, with the facilitator’s assistance, a comparison of shame and sexual shame in the same fashion.

6. Discuss the concept of "SHAME-BASED SELF" and integrate it with the handout titled "SIGNALS THAT SHAME EXISTS." As appropriate, enlist group participation around how the individual residents can identify their own shame and sexual shame signals.

7. As a shame-based individual or a shame-bound system develops, discuss "FIGURE 3.3, THE SHAME-BOUND CONTROL--RELEASE TRIGGERS." Engage the group in general discussion
of identification of their own release triggers around shame.

8. Introduce/discuss the formation of shame and the formation of sexual shame and engage the group in general discussion to identify how this occurred for them in their individual lives.

ASSIGNMENTS:

From their manual, give the residents individual writing assignments on the following two questions:

1. How did shame and sexual shame influence my sexual acting out behaviors?

2. What is my plan for resolving my sexual issues before I leave treatment in Journey Cottage?

3. Divide the residents into equal groups. As a group, have them meet to discuss the question: What sexual shame issues do I need additional work/focus on, while in Journey Cottage?

4. Have the handout titled "SEXUAL SHAME" completed before the start of Section XI.

SESSION ACTIVITIES:

1. As a group discuss/process the two individual written assignments and the group assignment.

2. Turn to the handout assignment from section X and briefly review the responses as a means of introducing a discussion on specific influences that can effect/create experiences of sexual shame.

3. Introduce and discuss, using specific examples, the chart distinguishing Toxic Guilt, Healthy Guilt, Toxic Shame, and Healthy Shame.

4. Introduce and discuss the "CYCLE OF SHAME" involving the residents in providing examples to illustrate specific points in the cycle.

5. Introduce and discuss "Family Rules of Shame-Bound Systems." Engage the residents in giving examples and discussing how shame and/or sexual shame affected them, based on this specific family rule.

6. Discuss the process of therapeutic shame reduction/resolution. As appropriate, have individual
residents discuss ways they have done shame reduction to date in their treatment experience.

7. Using the handouts titled "AFFIRMATIONS" and "SELF-ESTEEM AFFIRMATIONS." introduce and discuss how the use of affirmations can be a means for rebuilding one's self-esteem from either shame or sexual shame experiences.

ASSIGNMENT:

Have the residents complete an individual writing assignment and turn in at the beginning of Section XII: What is the Relationship Between My Sexual Shame and My Sexual Assault Cycle?
SECTION IX

Introduction to Sexual Abuse Cycles

OBJECTIVES:

1. To introduce the residents to the Sexual Abuse Cycles and to discuss with each resident how they progress through their own cycles as it pertains to their sex education studies.

2. To recognize how residents assimilate their behaviors through a series of thinking errors.

3. To reinforce the Sexuality Team's approach to the Sexual Abuse Cycles how the residents are taught to interrupt their cycles with appropriate coping responses.

4. To teach the juvenile sex offender to clarify the Assault Cycle.

SESSION ACTIVITIES:

1. Each resident is to bring to the next session his own Assault Cycle worksheet for review, clarification and discussion.

TO THE TEACHER

Each individual may exhibit different rates of progression through the cycle. The rate may depend on the adequacy of the maladaptive coping response and the individual's tolerance of anxiety and the associated thought processes. Progression through the cycle is not necessarily consistent in that some overlap may occur or different phases of the cycle may be reached and a plateau maintained for a period of time before further progression. On one hand, the maladaptive coping response may be sufficiently gratifying that the individual may respond to a new situation, begin the cycle again, and continue to maintain at a particular plateau level any number of times before progressing further in the cycle. On the other hand the discomfort associated with the initial event may be so overwhelming to the individual that progression may be more rapid.
The specific details of events, thinking errors, feelings, goals, and behavior which precede, occur during, and follow a sexual offense, is defined as the cycle of assault. An assault is defined as any behavior which excludes the rights and welfare of others and causing harm to others or self. Assault may be sexual abuse, verbal abuse, or emotional abuse.

Sexual offense behavior is viewed as a middle step in a predictable sequence of predictable maladaptive behaviors. Feeling victimized by a sense of betrayal, helplessness or powerlessness appears to be the first step in this cycle, followed by a predictable pattern of maladaptive and acting-out behaviors, thinking errors, goals and feelings which are predictable and repetitive, and which conclude the final step of the cycle, that the offender is okay in his or her world.

Goals of Assault Behavior

The sexual offense and the maladaptive acting-out behaviors exist to meet normal human needs for self-esteem & personal power. While the human needs are shared by us all, the offender’s methods to get those needs met is harmful, exclusive of recognizing the rights and needs of others. The sexual offense and the preceding and post-assault behaviors appears to be efforts to achieve some personal equilibrium within the offender’s view of the world.

A Primary Treatment Goal

A primary goal of sex offender treatment is to aid the offender in accepting full accountability for his or her offense. Teaching an offender how to identify, recognize, and then interrupt his or her own assault cycle, serves this goal.

In order to teach clarification effectively to the offender, it is important for the therapist to understand 1) the value of clarifying the cycle; 2) the content of a generic cycle and the internal dynamic of recycling through an incomplete cycle; and 3) that individual identification is a means to learning how all acting-out behaviors are tied to assault.

Key Dynamics Within the Assault Cycle

Within the repeated sequence of maladaptive feelings and behaviors exists a potent dynamic foe change called recycling. It is a predictable departure from a series of predictable behaviors, and a re-entry to the beginning point
of cycle prior to an assault. It is a dynamic of self perpetrating stress. The offender is dysfunctionally failing to meet personal needs in mid-cycle and before the assault. The offender experiences being victimized by non-victimizing events and starts back through the cycle another time. Each repetition through an incomplete assault cycle, through return to a repeated sequence of thinking errors, feelings and behaviors serves to decrease esteem, and to increase the offender's practice to self protect in ways which exclude and increasingly exploit the rights and needs of others. The process appears to escalate objectifying others, viewing others as objects.

Recycling functions as a buildup of increasing internal frustration and pressure. This pressure may be vented by acting-out behaviors or by fantasy of getting back at others. Initially, get-back fantasies serve as a pressure reducer. Recycling desensitizes an individual to the initially high degree of pressure release achieved by fantasy or acting-out behaviors. Repeating get-back fantasy as a maladaptive form of problem resolution, pressure release, or discharge of anger or hurt, may subsequently decrease in desired effect. Fantasy may need to become increasingly sensational, intrusive, or exploitive, in order for the individual to continue to derive the same rush, or relief. Like the alcoholic who increases the chemical to achieve the initial desired effect, the offender may need to advance fantasy to greater exploits and/or translate fantasy to action.
Offender Tactics Which Obstruct Clarifying Cycle

1. Declares "I don't remember.

2. Assumes no feelings exist.

3. Refocuses on another's behavior & their blameworthiness.

4. Overgeneralizes, fails to develop detail.

5. Defers to others to do the work.

6. Uses vagueness.

7. Passive, remains silent.

8. Accuses others of not understanding.

9. Copies another's work.

10. Refuses to work.

11. Claims incomplete work is complete.

12. Stays confused.

Clinician Response

Direct to "guess."

Assigns feeling list.

Refocus client on own behavior.

Explore one point, overmagnify related behaviors & feelings.

Recognize what is done, refuse to cheat the client out of self discovery.

Advise client to "get clear," repeat firmly.

Define silence as a form of assault.

Refocus client on ways to get heard. Agree, magnify listening.

Explore similarities of cycles, refocus on individual differences.

Proceed with drafting partial cycle, engage client to confirm or disqualify your guesses.

Clarify initial goal is the process, not the end, request 5 new points under each item.

Focus on what is known. Get confused with the client and have the client straighten you out.
SECTION X

Relapse Prevention - Plan I

OBJECTIVES:

1. To develop an understanding of all elements that lead to offending behaviors.

2. To learn to separate external and overt from internal and covert stress/influences that effected the decision to offend and subsequent offending behaviors. To introduce the concept of "fire drill strategies."

3. To understand, build, practice, and develop effective coping strategies. To develop relapse rehearsal contracts.

ACTIVITIES:

1. Facilitator frames the importance of relapse prevention by asking the following questions and soliciting appropriate responses from the group:

   a. What is the relationship between your assault cycle and relapse? There is a direct correlation between the depth of understanding of the relationship between their assault cycles and relapse, and the quality of their relapse prevention program.

   b. What are the threats to your relapse? This question deals with both internal/external triggers and overt/covert cues. If it seems appropriate, the facilitator can use a blackboard or easel pad to engage the group in some general discussion of what some of these triggers and cues have been in relation to past offending behaviors.

   c. What would be the most likely situation that would cause you to relapse? It is most important to discuss this question from a therapeutic perspective rather than one creating a euphoric recall. If done properly, the facilitator can challenge the residents to write out their most likely relapse scenario or use group discussion to dismantle and properly identify all of the component parts involved in relapse.

2. Using the handout entitled "DECISION MATRIX" create/develop a couple of scenarios to illustrate the component parts of the decision matrix as it relates to the reality of relapse.
3. Introduce the concept of "FIRE DRILL STRATEGIES" which are defined as:

a. A routine series of steps put into action immediately should trouble be eminent.
b. An automatic protection (insurance plan).

The success of the fire drill strategy depends upon:

a. A clear alarm or clear sign of trouble.
b. The ability to identify very concrete steps to be taken by the individual.
c. A routine/regular way to practice the component parts of the fire drill.

4. Using the blackboard or easel pad, engage the group in a brainstorming exercise of listing elements of fire drill strategies that could regularly be employed.

5. Using the "RELAPSE PREVENTION PROGRAM I" discuss each of the items on the plan to ensure all residents have an understanding of what is expected on the plan.

ASSIGNMENT:

Using "RELAPSE PREVENTION PROGRAM I" announce that it is to be turned in within one week. Review of each plan will be done by the facilitator and reviewed with the Journey Treatment Team to determine any additional strategies that may be needed in dealing with individual resident information contained in each of the plans.
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SEX EDUCATION II

SECTION I

Sexual Orientation

OBJECTIVES:

1. To provide a working and functional definition of "SEXUAL ORIENTATION" useful to the resident population.

2. To describe and discuss the evolution of the theories dealing with sexual orientation.

3. To discuss societal prejudices and biases about sexual orientation.

4. To allow residents an opportunity to consider individual issues of their personal orientation.

SESSION ONE

1. To provide an etiological and historical perspective of the development of sexual orientation, beginning with Kinsey, Pomeroy and Martin (1948) describing the 7 point scale developed by Kinsey and his associates. (Using figure 1, display scale on easel).

   1. Zero on the continuum represents exclusive heterosexuality.

   2. Six on the continuum represents exclusive homosexuality.

   3. Three on the scale represents equal homosexual and heterosexual responsiveness.

   The rating on the continuum is based upon 1, individual's sexual behavior, and 2, individual's psychic reactions, i.e., physical attraction to desired partner. Limitations of the Kinsey's scale are that the scale assumes that sexual behavior and erotic responsiveness are the same within individuals.

2. Describe and discuss "SEXUAL ORIENTATION."

3. Using the lesson entitled "HETEROSEXUAL QUESTIONNAIRE" choose some appropriate questions to engage the residents in some general discussion.

4. Involve some general discussion around the topic of homophobia using the assignment "WHAT IS HOMOPHOBIA."
ASSIGNMENTS:

1. Have all residents complete the Klein Sexual Orientation Grid (KSOG) to be turned in prior to the next session of Sex Education II to give you time to review the information contained on the grid.

2. Have the residents complete "ASSESSMENT OF SEXUAL ORIENTATION" to be turned in prior to the next Sex Education II session to give you sufficient time to review the information contained in the assignment.

3. Have the residents complete "INDEX OF HOMOPHOBIA" (IHP) to be turned in prior to the next session to give you the opportunity to review the information and rate the instrument.

4. As needed, assign specific questions from the page entitled "HETEROSEXUAL QUESTIONNAIRE" that you feel are appropriate to be addressed by the residents, either for individual work or in anticipation of a group discussion.

DEFINITIONS

HOMOPHOBIA - The irrational fear of sexual orientation other than heterosexuality. Homophobia is expressed as negative feelings, attitudes, actions or behaviors against lesbians, gay men, bisexuals, and transgender people. It includes the fear of:

1) lesbians and gay men.
2) being perceived as lesbian or gay.
3) one’s own feelings of affection for the same sex.

Homophobia has three components:
1) xenophobia - fear of differences.
2) erotophobia - cultural anxiety about sexuality, particularly fear of same sex sensual/sexual feelings and behaviors.
3) sexism - fear of sex role violation.

INTERNALIZED HOMOPHOBIA - The belief by lesbian/bisexual/gay people that same sex sexuality is inferior to heterosexuality. Internalizing this belief can lead to self-hate and difficulty with self-acceptance. Often bisexuals/lesbian/gay people accept society’s stigma attached to same sex orientation without realizing that their belief is the result of oppression.
HETEROSEXISM - The societal assumption and norm that the practices of heterosexuality are the only accepted and sanctioned expressions of human sexuality. Heterosexism presumes that everyone is or should be heterosexual. Heterosexism has become institutionalized in a way that sanctions discrimination and the denial of basic human rights for lesbian, gay, and bisexual people.

BIPHOBIA - The fear, hatred, or distrust of people who are attracted to and form romantic or sexual relationships with partners of any gender. It includes ignoring the existence of bisexuals by believing everyone is either gay or straight and a fear of being labeled a bisexual by others.

BISEXUAL - A man or woman whose primary erotic, psychological, emotional, and social interest is in a member of either sex. They prefer either other women or men on many levels; sexually, emotionally, intellectually, and physically—and who identifies themselves as bisexual.

LESBIAN - A woman whose primary erotic, psychological, emotional, and social interest is in a member of her own sex. She is a woman who prefers other women on many levels; sexually, emotionally, intellectually, and physically—and who identifies herself as a lesbian.

GAY MAN - A man whose primary erotic, psychological, emotional, and social interest is in other men. A gay man is someone who prefers other men on many levels; sexually, emotionally, intellectually, and physically—and who identifies himself as gay.

HETEROSEXUAL - A man or woman whose primary erotic, psychological, emotional, and social interest is in a member of the opposite sex. She/he prefers members of the opposite sex on many levels; sexually, emotionally, intellectually, and physically (Duce, 1991).
ATTITUDES TOWARDS DIFFERENCES: THE RIDDLE SCALE

Negative Levels of Attitudes

REPULSION People who are different are strange, sick, crazy, and aversive. Anything which will change them to be normal or a part of the mainstream is justifiable.

PITY People who are different are somehow born that way and that is pitiful. Being different is definitely immature and less preferred. To help those poor individuals, one should reinforce normal behaviors.

TOLERANCE Being different is just a phase of development that people go through and most people "grow out of." Thus they should be protected and tolerated as one does a child who is still learning.

ACCEPTANCE Implies that one needs to make accommodations for another's differences and does not acknowledge that another's identity may be of the same value as their own.

Positive Levels of Attitude

SUPPORT Works to safeguard the rights of those who are different. Such people may be uncomfortable themselves but they are aware of the climate and the irrational unfairness of our society.

ADMIRATION Acknowledges that being different in our society takes strength. Such people are willing to truly look at themselves and work on their own personal biases.

APPRECIATION Values the diversity of the people and is willing to confront insensitive attitudes.

NURTURANCE Assumes the differences in people are indispensable in society. They view differences with genuine affection and delight and are willing to be advocates of those differences (Riddle, 1987).
A Measure of Homophobia

The Index of Homophobia or IHP is a 25 item summated category partition scale with a score range from 0-100. Persons who have very little dread of being in close quarters with homosexual men or women tend to obtain very low scores on the IHP; those who have considerable dread or discomfort tend to obtain high scores. Persons who score 0-25 are regarded as "high grade non-homophobics." A person who scores between 50-75 is regarded as a "low grade homophobic." "High grade homophobics" score above 75 on the IHP.

In order to score the IHP it is first necessary to reverse score all of the negative worded items so that a score of 1-5, 2-4, 4-2, 5-1, and a score of 3 remains unchanged. For convenience, the numbers of all the items that must be reverse-scored have been listed (3, 4, 6, 9, 10, 12, 13, 14, 15, 17, 19, 21, 24).

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SECTION II

Gender Identity

OBJECTIVES:

1. Introduce and define the term gender identity as a term used for one’s sense of masculinity and femininity.

2. Discuss gender identity as a product of three kinds of responses to the environment: biological, biophysics, and intrapsychic, especially effects due to parental influences and societal attitudes.

3. Discuss and explore the definition of under-identity as stated:

   An individual’s view or belief that he/she belongs to a particular gender, supported by self identification and the identification of others.

   Discuss the manner in which self-identification and identification of others comes to be reality within an individual’s concept of their gender identity. To explore gender identity as a manner in which individuals refer how they view themselves overall in terms of masculinity and femininity.

4. To introduce and address the concept of "ANDROGYNY."

5. Discuss the influence of individuals, societal attitudes, beliefs, prejudices, and biases, as they relate to gender identity. Specifically, introduce the concept of male vs. female valued traits.
Stereotyped Traits

Male-Valued Traits

Aggressive
Independent
Unemotional
Hides emotions
Objective
Easily influenced
Dominant
Likes math and science
Not excitable in a minor crisis
Active
Competitive
Logical
Worldly
Skilled in business
Direct
Knows the way of the world

Feelings not easily hurt
Adventurous
Makes decisions easily
Never cries
Acts as leader
Self-confident
Not uncomfortable about being aggressive
Ambitious
Able to separate feelings from ideas
Not dependent
Not conceited about appearance
Thinks men are superior to women
Talks freely about sex men

Female-Valued Traits

Avoids harsh language
Talkative
Tactful
Gentle
Aware of feelings of others
Religious

Interested in own appearance
Neat in habits
Quiet
Strong need for security
Appreciates art and literature


6. Discuss the process of male socialization as it relates to gender identity.

SESSION ACTIVITIES

1. Discuss the various aspects involved in male gender identity and socialization to include:

A. Family
B. Peer Groups
C. Media, other societal institutions e.g., schools, religious institutions.
2. Discuss selected aspects of the "FREIMUTH & HORNSTEIN'S ASPECTS OF GENDER MODEL" to include:

A. Gender-Related Physical Characteristics
B. Gender Role
C. Gender Preference
D. Subjective Gender Identity

An illustration of Freimuth & Hornstein's Aspect of Gender Model

Gender-Related Hormones

<table>
<thead>
<tr>
<th>Androgen hormonal level relative to estrogen/progestin level</th>
<th>Androgen hormonal level relative to estrogen/progestin level</th>
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</thead>
<tbody>
<tr>
<td><strong>High</strong> (Masculine)</td>
<td><strong>Low</strong> (Feminine)</td>
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</table>

Gender-Related Physical Characteristics

(Genitals, body size, hip size, facial hair, etc.)

<table>
<thead>
<tr>
<th>Physical characteristics associated with males</th>
<th>Physical characteristics associated with females</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Masculine)</strong></td>
<td><strong>(Feminine)</strong></td>
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</table>

Gender Role

(Culturally defined behaviors)

| **(Masculine)**                               | **(Feminine)**                                |

Gender Preference

Basis of Choices of Sexual Partner and Frequency of Such Choices

<table>
<thead>
<tr>
<th>All gender related characteristics the same as one's own</th>
<th>All gender related characteristics different than one's own</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> (Homosexual)</td>
<td><strong>(Heterosexual)</strong></td>
</tr>
<tr>
<td><strong>B.</strong> (Always)</td>
<td><strong>(Never)</strong></td>
</tr>
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Subjective Gender Identity

(One's conception of one's own gender overall--both in terms of physical and psychological characteristics)

| **(Masculine)**                                           | **(Feminine)**                                           |

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Let's begin by examining Freimuth and Hornstein's (1984) work. Freimuth and Hornstein point out first of all that differences between males and females on a hormonal basis are differences in degree rather in kind. Both males and females possess androgens, estrogens, and progestines. For males, however, the androgen hormonal level is higher relative to the estrogen/progestin levels. Females' estrogen/progestin levels are much higher than their androgen levels. Because both males and females possess all three hormones, maleness and femaleness becomes a matter of degree and is handled best when viewed as a continuum.

A second aspect of gender proposed by Freimuth and Hornstein is gender-related physical characteristics. Including but going beyond the genital/reproductive structure of a person, the authors note the irony of most judgements of a person's gender. We judge a person's gender often on the basis of, or at least in part, secondary sex characteristics but we describe our judgements in terms of the two typical genital reproductive-structure categories into which most people fall: male or female. Yet we do not see most people's genitals, but we do make gender attributions based on secondary sex characteristics and even on other physical characteristics. Because some of these other physical characteristics are culturally defined arbitrarily as masculine or feminine, additional variations in a person's masculinity and/or femininity can't be expected. Freimuth and Hornstein feel that when judgements are made about a particular person's masculinity and/or femininity based on physical appearance, comparisons are made with some prototype of physical masculinity and/or femininity. Their view is that the above gender-related physical characteristics "constitute a continuum dimension, ranging from clear cases of masculinity at one end to clear cases of femininity at the other (p. 524).

The third aspect of gender, according to Freimuth and Hornstein, is gender-role which they limit to include behaviors and societal traits associated to masculinity and femininity. Arguing against a dualistic view of masculinity and femininity, the authors propose a bipolar view of some individuals, typically called "androgynous" persons, falling at the midpoint. Gender preference as an aspect of gender is also seen from a continuum perspective. Pointing out that the conceptualization of gender preference is limited to genital structure, Freimuth and Hornstein, note that a reliance entirely upon genital structure to define a person's gender choice is inappropriate. Such a
reliance does not take into consideration the fact that other gender-related characteristics are related to choices of a person's sexual partner. In a provocative manner, Freimuth and Hornstein state that the preference of a masculine male for a feminine female is different from a preference of a masculine male for a masculine female. If we go beyond genital structure and thus are able to say that individuals are more or less heterosexual, homosexual, or bisexual, we conclude axiomatically that the latter "masculine" male above is more homosexual or bisexual than the former "masculine" male.

The final aspect of gender considered by the authors is subjective gender identity which refers to how persons view themselves overall in terms of masculinity and femininity. This view of self, according to Freimuth and Hornstein, involves more than a person's knowledge of his or her genital structure; it involves also a person's organized conception of those continuously distributed physical or psychological characteristics of self which she or he believes relevant to gender. This means that subjective gender identity is "a statement about one's relative masculinity or femininity" and, like the other aspects of gender, can be thought of as existing along a continuum ranging from clear masculinity to clear femininity (p.529). Given Freimuth and Hornstein's observations, let us propose a definition of masculinity that may conform to persons more highly "masculine" and those who are low on "masculinity" (Franklin III, 1984).

3. Involve the residents in general discussion about how their own individual life experiences have presented issues or problems for them in their struggle to understand gender identity.
SECTION III

Victim Empathy

OBJECTIVES:

1. To define the concept of victim empathy.

2. To create and heighten the resident's awareness of their own victimization, as well as the victims they created as a result of their perpetrating behaviors.

3. To explore how defense mechanisms/cognitive distortions affected thinking about their own victimization and perpetration.

4. Distinguish between sympathy and empathy. To discuss the general developmental process of empathy.

SESSION ONE:

1. Using the board or easel pad, engage the residents in a general discussion of developing a working definition for empathy.

2. Using the handout entitled "DEFINITIONS OF COGNITIVE DISTORTIONS" begin general group discussion of the particular cognitive distortions and the manner in which they were involved in:

   a. Their own victimization.
   b. Their own perpetration.

   Using the blackboard or easel pad, develop a chart/side-by-side list of the cognitive distortions and the effects.

3. Using the blackboard or easel pad, involve the group in a general discussion of listing the effects of their own victimization on themselves and the effects of their perpetration on their victims. Draw comparisons and make group comments as appropriate.

4. Introduce and discuss the concepts of responsibility and accountability for one's behaviors. Engage the group in general discussion, using the blackboard or easel pad, about their understanding and awareness of their present level of responsibility and accountability as it relates to their offending behavior(s). Discuss how this understanding enhances their victim empathy.
ASSIGNMENTS:

1. Individual writing assignment to answer the question, "WHAT IS THE DIFFERENCE BETWEEN FORGIVING AND FORGETTING?"

2. Have the residents list the three most important skills he needs to work on to further develop victim empathy as he moves to Re-entry, and complete the handout "WHAT IS MY PLAN TO WORK ON THESE THREE SKILLS?"

SESSION Two

1. Discuss the written assignment using the blackboard or easel pad to distinguish between forgiving and forgetting.

2. Using the blackboard or easel pad begin a list of the various skills identified as needing work around victim empathy. Engage the group in general discussion about how they can go about building the skills while in the Journey program at Adobe.

3. Discuss the general process of victim empathy to include:
   a. Victim(s) letter(s).
   b. Victim(s) apology.
   c. Victim(s) reconciliation.

Discuss the difference between these three elements and the specific therapeutic tasks involved in each of the three.

4. Discuss forgiveness vs. forgetting. It is important to make the point, according to Mike Lew in his book "VICTIMS NO LONGER," "it is not necessary to forgive the person who abused you!" In specifically making the point that this goes for both the victim and a perpetrator. The choice to forgive or not to forgive is strictly the individual's. Forgiveness must be considered within the context of moral, ethical, and cultural values. If the idea of forgiveness is accepted, the individual is the one to decide when the time is appropriate. Asking for forgiveness or forgiving is not a process that can be rushed.

In talking about forgiving, Lew makes the following points:

   a. Take your time. Don't rush to forgive.
   b. Protect yourself. Be aware of getting trapped
by pity. Be careful not to yield to inclination to protect or take care of a perpetrator.

c. Explore your real feelings. Consider forgiveness.

d. You can change your mind. What is appropriate at one point in your life, may not feel or seem appropriate at another point.

e. Forgiveness takes different forms.

f. It isn't "all or nothing." Forgiveness doesn't have to be total. A little can go a long way.

g. Think about what you mean by forgiveness. It is important that, in the process of forgiving a person, we do not condone the abuse.

Lewis B. Smedes, from his book "FORGIVE AND FORGET," describes what forgiveness is not.

a. Forgiveness is not forgetting. By forgiving someone, we do not forget the hurting act. We need to forgive precisely because we have not forgotten what someone did; our memory keeps pain alive long after the actual wrong doing is passed. Because forgiving is healing, it will make it easier to forget, but it is not necessary to forget the past in order to forgive. What forgiving will accomplish is to heal the pain of the past.

b. Forgiving is not excusing. Excusing is the opposite of forgiving. We excuse a person when we believe that he is not to blame. This is why excusing is easy and forgiving is hard.

c. Forgiving is not tolerating. We can forgive someone without tolerating what they did.

d. According to Jennifer P. Schneider, M.D., from her book, "BACK FROM BETRAYAL," she states, "forgiveness is healing ourselves of the painful memories of the past. This is a slow process that may take years."
SECTION IV

Healthy/Positive Sexuality

OBJECTIVES:

1. To explore the elements to positive and healthy sexuality from both an individual and relationship perspective.

2. To understand the difference between sex and intimacy.

3. To provide a definition for intimacy.

4. To develop an understanding of the facets and components of intimacy.

SESSION ONE:

1. Using a blackboard or easel pad, engage the group in general discussion of defining the terms "SEX" and "INTIMACY." Note similarities and differences, then use examples to illustrate important points.

2. Using the "CIRCLE OF INTIMACY" reference from Sex Education I, Section IV, discuss the fact that more than one model has been developed to explain the concept of intimacy.

3. Using the "FACETS OF INTIMACY" lesson, engage the group in general discussion about examples of the various facets of intimacy they can identify from areas of their own lives. Draw parallels from the "Facets of Intimacy" that would illustrate unhealthy types of sexuality.

4. Using the lesson entitled "GUIDELINES FOR INTIMACY" engage the group in general discussion and presenting of examples to illustrate healthy guidelines vs. unhealthy guidelines.

ASSIGNMENTS:

1. Have all individuals complete the "INTIMACY INVENTORY" before the start of the next session.

SESSION TWO

1. Discuss/process any group reactions to the "INTIMACY
INVENTORY." The scoring for the inventory is in the Student Manual. Encourage each resident to score his or her own inventory and discuss/process the scores.

2. Using the lesson entitled "HEALTHY SEXUALITY" discuss and give examples of each dimensions from both an individual and a diadic relationship perspective.

3. Using the lesson entitled "GUIDELINES FOR HEALTHY SEXUALITY" discuss and give examples as appropriate of the individual guidelines.

4. Engage the group in a general discussion, using the above point as a springboard, to address the question: "HOW WILL I KNOW WHEN TO BECOME SEXUAL IN A RELATIONSHIP?" Concentrate on listening for the process described and the elements of mutuality and consensual in the responses.

5. Using the lesson titled "NINE ASPECTS OF LOVE" discuss and ask the group for examples that would illustrate the various points.

ASSIGNMENTS:

1. Individual written assignment to be turned in at the beginning of the next session. Answer the question: "WHAT ARE MY THREE MOST IMPORTANT ASPECTS OF POSITIVE/HEALTHY SEXUALITY?"
* Scoring and Interpreting the Intimacy Inventory

The inventory measures fifteen attitudes that can rob you of self-esteem and make it more difficult to develop friendships and intimate relationships. Each attitude is represented by four statements on the inventory which are listed in the middle column of Table 2-1. Each of these four statements can be scored between 0 (if you "never" feel this way), and 3 (if you feel this way "a lot"). Your total score for each of the fifteen attitudes can range between 0 (indicating you answered "never" on all four statements that measure that attitude) and 12 (indicated you answered "a lot" on all four statements).

Add up your score on each of the fifteen attitudes and fill in your scores in Table 2-1. A score between 0 and 2 indicates a particular attitude is probably not a problem for you. A score between 3 and 5 indicates this attitude may be causing you mild problems. A score between 6 and 8 on an attitude indicates a moderate problem, and a score between 9 and 12 indicates that an attitude could be a significant problem for you.

* The scoring guide is included in the Students Manual.
<table>
<thead>
<tr>
<th>Attitude</th>
<th>Statements on the Intimacy Inventory That Measure The Attitude</th>
<th>Put Your Total Scores for The Attitude Here</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Low self-esteem</td>
<td>1, 11, 31, 47</td>
<td></td>
</tr>
<tr>
<td>2. Romantic perfectionism</td>
<td>9, 12, 43, 58</td>
<td></td>
</tr>
<tr>
<td>3. Emotional perfectionism</td>
<td>29, 48, 49, 53</td>
<td></td>
</tr>
<tr>
<td>4. Shyness and social anxiety</td>
<td>3, 10, 20, 51</td>
<td></td>
</tr>
<tr>
<td>5. Hopelessness</td>
<td>14, 22, 33, 52</td>
<td></td>
</tr>
<tr>
<td>6. Alienation and isolation</td>
<td>18, 28, 36, 41</td>
<td></td>
</tr>
<tr>
<td>7. Rejection sensitivity</td>
<td>5, 21, 32, 39</td>
<td></td>
</tr>
<tr>
<td>8. Fear of being alone</td>
<td>2, 6, 23, 57</td>
<td></td>
</tr>
<tr>
<td>9. Desperation</td>
<td>13, 26, 37, 42</td>
<td></td>
</tr>
<tr>
<td>10. Disclosure phobia</td>
<td>4, 24, 27, 56</td>
<td></td>
</tr>
<tr>
<td>11. Inassertiveness</td>
<td>8, 15, 34, 60</td>
<td></td>
</tr>
<tr>
<td>12. Resentment and bitterness</td>
<td>17, 35, 45, 59</td>
<td></td>
</tr>
<tr>
<td>13. Defensiveness and fear of criticism</td>
<td>19, 25, 30, 44</td>
<td></td>
</tr>
<tr>
<td>14. Depression</td>
<td>16, 38, 50, 55</td>
<td></td>
</tr>
<tr>
<td>15. The trapped factor</td>
<td>7, 40, 46, 54</td>
<td></td>
</tr>
</tbody>
</table>

To determine your total score for each attitude, simply add up your score for the four statements in the middle column.
SECTION V

Individual Sexuality Plan

OBJECTIVES:

1. Building off the previous topic "HEALTHY/POSITIVE SEXUALITY," discuss the necessity of developing an INDIVIDUAL SEXUALITY PLAN prior to the completion of an individual resident's treatment in the Journey program at Adobe Mountain School.

2. To identify and discuss the various elements that comprise an individual sexuality plan.

3. To discuss/explore appropriate vs. inappropriate times at which to introduce sex into relationships.

SESSION ONE

1. Involve the group in a general discussion of the question "WHAT ARE THE ELEMENTS/CHARACTERISTICS OF RESPONSIBLE INDIVIDUAL SEXUAL BEHAVIOR?" Use the group to engage in general discussion and further qualification by giving examples when appropriate.

2. Engage the group in general discussion of "WHAT PART DOES PRACTICING SAFE SEX HAVE IN AN INDIVIDUAL SEXUALITY PLAN?" Facilitator should frame this discussion within the context of mutuality, consensual, choice making around safe sex, responsibility and accountability regarding safe sex, etc.

3. This question can build on the previous question. Engage the group in general process of the question "SHOULD CONDOMS BE GIVEN OUT IN SCHOOLS? WHY OR WHY NOT?"

4. Using the diagram of healthy and unhealthy habit behavior, give examples of both the healthy illustrations and the unhealthy illustrations. Point out how the illustrations have an effect on choice making with respect to the INDIVIDUAL'S SEXUALITY PLAN. These illustrations will introduce the concepts of self-defeating thoughts and behaviors as opposed to healthy thoughts and behaviors around the INDIVIDUAL'S SEXUALITY PLAN.
ASSIGNMENTS:

1. Using the exercise titled "WHAT SEXUAL BEHAVIORS DO YOU NEED TO CHANGE?" have each resident complete the exercise prior to the start of the next session.

2. Using the exercise titled "THREE REASONS WHY WE CONCEAL OURSELVES" ask the residents to read the exercise and be prepared to respond at the start of the next session.

SESSION TWO

1. Begin this session by referencing the exercise from last session on "THREE REASONS WHY WE CONCEAL OURSELVES." Engage the residents in a general discussion of how this has affected or can affect their INDIVIDUAL SEXUALITY PLAN.

2. Introduce/discuss the various components of the INDIVIDUAL SEXUALITY PLAN worksheets.

ASSIGNMENTS:

1. Have all residents complete the INDIVIDUAL SEXUALITY PLAN and turn it in at the start of the next session.
SECTION VI

Self-exploration & Self-Pleasuring

OBJECTIVES:

1. To discuss the use of senses within the context of individual self-pleasuring.

2. To discuss the concept of self pleasuring within the context of preventative health techniques.

3. To discuss the concepts of full body focus.

SESSION ONE

1. Using the blackboard or easel pad, record and discuss their responses to two separate questions:

   a. "WHAT IS SELF-PLEASURING?"
   b. "WHAT IS SELF-EXPLORATION?"

   In the process of discussion, have them respond to and list the elements of both self-pleasuring and self-exploration.

2. Engage the group in a discussion of the five senses in relation to self-pleasuring and self-exploration. Using the blackboard and easel pad, list ways to experience the senses and heighten sensory awareness with certain techniques of self-exploration or self-pleasuring.

3. Introduce the concept of "FULL BODY FOCUS/MASSAGE" and discuss within the context of preventative health techniques and self-pleasuring.

4. Show the film titled "DAVID." After the film, process the reaction of the residents as a group, noting information that was new to them, aspects of the film that were uncomfortable. Discuss general reasons for the discomfort and discuss techniques from the film that they can integrate into their own self-pleasuring and self-exploration routines.

ASSIGNMENTS:

1. Have all residents read and be prepared to respond to the exercise titled "GETTING IN TOUCH WITH YOURSELF."
2. Have all residents read and be prepared to respond to the article titled "MASTURBATION: TOUCHING ONESELF ANEW."

3. Have all residents complete and turn in at the start of the next session the exercise titled "MASTURBATION QUESTIONNAIRE."

SESSION TWO

1. Engage the group in general discussion of their reaction to the article titled "GETTING IN TOUCH WITH YOURSELF." Query the group to determine if anyone tried any of the suggestions on the handout and, if so, what was their reactions? Engage the group in general discussion of how this article can relate to their INDIVIDUAL SEXUALITY PLAN.

2. Engage the entire group in a general discussion of the article titled "MASTURBATION: TOUCHING ONESELF ANEW." What was their reaction to the article, what did they like, what did they dislike, what do they agree with, what do they disagree with, etc.

3. Engage the group in a general discussion as to their reaction to the exercise titled "MASTURBATION QUESTIONNAIRE."

4. Engage the group in a general discussion of the question "HOW DOES MASTURBATION RELATE TO SELF-PLEASURING AND SELF-EXPLORATION?" Spend a considerable amount of time discussing the fact that masturbation is merely one form of self-exploration and self-pleasuring one can use within the context of full body focus/pleasuring. Engage the group in a general discussion of healthy vs. unhealthy masturbatory practices and how they can change any present unhealthy practices.

5. Introduce and discuss the exercise titled "HOW TO LOVE YOURSELF" discussing each point and asking for examples. Frame within the context of how each of the points compliments a full body focus concept of self-exploration and self-pleasuring.

6. Using the exercise titled "BILL OF RIGHTS" empower the residents to understand they have a right to healthy self-exploration and healthy self-pleasuring and it is an individual choice. Suggest that they may need to have further discussion with their Sexuality Therapist concerning any conflicts that they may have regarding
this point.

7. Using the handout titled "SELF-ESTEEM AFFIRMATIONS" discuss the general theory behind the use of affirmations relative to a larger context of self-pleasuring. Give them other examples of things they can do similar to self-affirmations that will enhance one's experience of self-pleasuring.

ASSIGNMENTS:

1. An individual writing assignment given to respond to the question of "WHAT'S SMART TO DO AND NOT TO DO ON A FIRST DATE?" This should be turned in at the start of the next group and will become the point of group discussion.

2. Divide the larger group into smaller working groups. Open the manual to the copy of the article "THE MASK OF RAPE." The smaller working groups are to discuss and present in the next session of Sex Education II, what information the article communicated to them and what they learned from the article.

3. Also within the context of item number two above, the smaller groups should also address the question and be prepared to give a group response to the question "CAN WHAT A GIRL WEARS PROVOKE RAPE?"
SECTION VII

Dating Issues

OBJECTIVES:

1. To develop an understanding of healthy dating behaviors.

2. To discuss healthy stages of relationship development.

3. To understand how relationships are nurtured and maintained.

4. To emphasize personal responsibility and accountability, decision making and behavior, with respect to dating issues.

5. To assist group members in understanding the dynamics of acquaintance rape and dispel myths relating to rape.

SESSION ONE

1. Discuss/process the assignments from the previous session. Use the assignments as a segue into the topic of dating.

2. Using the handout titled "WHAT MAKES A FRIENDSHIP WORK?" describe the components of friendship. Introduce the idea that dating is based on friendship first, and other aspects, with respect to dating, develop after the establishment of a healthy friendship relationship. Give examples or solicit examples as appropriate.

3. Using the handout titled "ARE YOU A GOOD FRIEND?" challenge the individual residents to look at how they perceive themselves in terms of friendship toward others. Past problems in dating relationships may be able to be identified by some of the points on this handout.

4. Using the handout titled "FIVE STAGES OF A RELATIONSHIP" discuss the various stages and give examples.

5. Using the handout titled "NUPTURING RELATIONSHIPS" discuss the concepts of relationship regression, development, and healthy growth, from the points made on the handout. Engage the group in discussion and examples as appropriate.
6. Using the handout titled "BEHAVIORS/ATTITUDES THAT ARE HARMFUL TO RELATIONSHIPS" discuss the importance of behaviors and attitudes in a relationship. Have the residents give examples of behaviors and attitudes that are nurturing to a relationship. Discuss how when two individuals find something that attracts them to one another, there is a sense of mutual attraction that pulls them together. As that mutual attraction develops they begin to form a diadic relationship (the "US/WE"). Describe how in healthy relationships the individuals continue to maintain their sense of individuality and set separate boundaries for needed personal aspects of their lives. Point out the fact that an easy way to determine the point at which a relationship began to change is for one or both parties in the relationship to ask themselves the question "When did I notice the decrease in the use of the 'US/WE WORDS?'"

7. Using the handout titled "THE BASIC DIMENSIONS OF TRUST" discuss the importance of trust in all healthy relationships and how trust is developed and nurtured. Ask the group for examples of how their past behavior has effected trust and subsequently their relationship(s).

8. Using the handout titled "QUALITY OF HEALTHY RELATIONSHIPS" discuss and give examples of each of the qualities.

9. Using the newspaper article titled "BEING SEXUALLY ACTIVE 'THE NORM' FOR TEENS AT STEADILY YOUNGER AGE" discuss the role of sex in relationships. Engage the group in discussion of the question AT WHAT POINT IN A RELATIONSHIP SHOULD SEX ENTER THE RELATIONSHIP, AND HOW SHOULD IT BE INTRODUCED?"

ASSIGNMENTS

1. Have the residents read the newspaper article titled "I DON'T EVER WANT TO SEE YOU AGAIN" and be prepared to discuss it in the next session.

2. Have the residents complete the assignments titled "QUALITIES I'M LOOKING FOR IN A DATE," and "QUALITIES I OFFER TO A DATE" to be handed in at the start of the next session.
3. Break the group into smaller working groups in which each smaller working group will be expected to respond in the next session to the following questions:

1. How does date rape usually occur?
2. What are the causes of date rape?
3. What is the difference between seduction and rape?
4. What can you do to avoid situations that might lead to date rape?
5. What are the effects of date rape?

SESSION TWO:

1. Discuss general reaction or comment on the two newspaper articles. Tie them back to the topic of dating issues with examples as needed.

2. Ask the group the general question "WHAT DID YOU LEARN ABOUT YOURSELF AND A PROSPECTIVE DATE BY THE WRITING ASSIGNMENT?"

3. Using the lesson titled "RELATIONSHIPS - INTIMATE VERSUS ADDICTIVE" discuss the differences between the two types of relationships providing or soliciting examples as it seems appropriate.

4. Engage the small working groups in presentations and discussion of their responses to the five questions leading to date rape. Use the lessons in the manual to discuss specific points relative to the five, small group discussion questions.

5. Discuss the concepts of the quality, domination, exploitation, and mutual respect as it relates to unhealthy vs. healthy relationships. This also is a segue into the concept of acquaintance/date rape.

6. Using the lesson titled "REAL MEN DON'T RAPE" discuss the key points made in the lesson and engage the group in discussion and examples as it seems appropriate.

7. Read and discuss with the group the article "PARENTS OFTEN LEARN TOO LATE ABOUT ABusive BOYFRIENDS."

8. Using the handout titled "PRACTICE FIGHT-FAIR RULES" and "RULES FOR FAIR FIGHTING." Engage the group in general discussion about how relationships handle disagreements and/or arguments.
9. Discuss the handout titled "SOME POSSIBLE BARRIERS THAT MAY BLOCK COMMUNICATION."

10. Using the lesson titled "DATING AND SEXUAL BEHAVIORS" have the group entertain the questions at the bottom of the page or those that the facilitator deems to be most appropriate.

Show video: "HOW CAN I TELL IF I’M REALLY IN LOVE?"
SECTION VIII

Repayment to the Community

OBJECTIVES:

1. To explore beliefs about restitution/repayment to the community.

2. To develop a clear understanding of the purpose and function of treatment.

3. To discuss individual options available for additional community service.

4. To distinguish between treatment and rehabilitation.

5. To discuss the transitional issues involved in the processes of Re-entry and Independent Living related to relapse prevention planning.

SESSION ACTIVITIES:

1. Engage the group in general discussion, using the blackboard or easel pad, in defining the terms "RESTITUTION," and "REPAYMENT TO THE COMMUNITY."

Facilitator will share appropriate parts of Webster's dictionary definition to properly frame further discussion of these terms.

Webster's New World Dictionary, 1977:

RESTITUTION: 1. Restoration to the rightful owner of something lost or taken away. 2. A making good for loss or damage. 3. A return to a former condition.

REPAYMENT: 1. a) To pay back (money); refund. b) To pay back (person). 2. To make some return for (repay a kindness). 3. To make some return to (a person), as for some service; to make a repayment or return.

2. Engage the group in a discussion of treatment and rehabilitation and the differences between their treatment and rehabilitation. Using the blackboard or easel pad, develop definitions for both words.
A working definition of treatment is:

TREATMENT ASSISTS IN ELIMINATING OFFENDING BEHAVIORS; REMOVES THE INDIVIDUAL FROM THE ENVIRONMENT WHERE PRIMARY OFFENDING/ACTING OUT BEHAVIORS OCCURRED; TEACHES A FRAMEWORK TO DISCOVER AND UNDERSTAND THE UNDERLYING CAUSE OR FACTOR FOR THE CHOICES MADE TO OFFEND; TEACHES NEW SKILLS AND COPING MECHANISMS FOR GENERAL LIFE STRESSORS; PROVIDES A SAFE ENVIRONMENT IN WHICH NEW SKILLS AND BEHAVIORS CAN BE PRACTICED AND MODIFIED IN A "CONTROLLED" ENVIRONMENT; ASSISTS THE INDIVIDUALS IN THE DEVELOPMENT OF "FIRE DRILL STRATEGIES" AND FORMALIZED RELAPSE PREVENTION PLANS TO ASSIST IN POST TREATMENT TRANSMISSION AND RE-ACCLAMATION TO COMMUNITY LIVING SITUATIONS.

A working definition of rehabilitate is:

TO RESTORE TO RANK, PRIVILEGES OR PROPERTY THAT ONE HAS LOST; TO RESTORE THE GOOD NAME OR REPUTATION OF; REINSTATE IN GOOD REPUTE; TO PUT BACK IN GOOD CONDITION; REESTABLISH ON A FIRM SOUND BASIS; TO BRING OR RESTORE TO A NORMAL OR OPTIMAL STATE OF HEALTH, CONSTRUCTIVE ACTIVITY, ETC. BY MEDICAL TREATMENT AND PHYSICAL OR PSYCHOLOGICAL THERAPY.

Rehabilitation is often mistaken to be synonymous with treatment. Rehabilitation is the result of the process of treatment. Rehabilitation is a process of assisting an offender to change so that he or she will not continue to repeat the pattern of offending behaviors.

3. Engage the group in general discussion around the question "DOES TREATMENT REHABILITATE OFFENDERS? WHY/WHY NOT?"

4. Engage the group in general discussion of the question "DOES TREATMENT CONSTITUTE RESTITUTION OR REPAYMENT? WHY/WHY NOT?"

5. Engage the group in a general discussion of types of activities they can brainstorm that could constitute restitution/repayment to the community.

ASSIGNMENT:

An individual writing assignment to be handed in at the next session (and incorporated into Relapse Prevention Program II), "WHAT THREE ACTIVITIES WILL I COMMIT TO BECOME INVOLVED IN THAT WILL CONSTITUTE RESTITUTION/REPAYMENT TO THE COMMUNITY?"
SECTION IX

Relapse Prevention Program II

OBJECTIVES:

1. To develop an understanding of all elements that lead to offending behaviors.

2. Learn to separate external and overt stress/influences that affected the decision to offend and subsequent offending behaviors. To introduce the concept of "FIRE DRILL STRATEGIES."

3. To understand, build, practice, and develop effective coping strategies. To develop relapse rehearsal contracts.

ACTIVITIES:

1. Facilitator frames the importance of relapse prevention by asking the following questions and soliciting appropriate response from the group:
   
a. What is the relationship between your assault cycle(s) and relapse? There is a direct correlation between the depth of understanding of the relationship between their assault cycles and relapse and the quality of their relapse prevention program.

b. What are the threats to your relapse? This question deals with both internal/external triggers and overt/covert cues. If it seems appropriate, the facilitator can use a blackboard or easel pad to engage the group in some general discussion of what some of these triggers and cues have been in relation to past offending behaviors.

c. What would be the most likely situation that would cause you to relapse? It is most important to discuss this question from a therapeutic perspective rather than one creating euphoric recall. If done properly, the facilitator can challenge the residents to write out their most likely relapse scenario or use group discussion to dismantle and properly identify all of the component parts involved in relapse.
2. Using the handout titled "DECISION MATRIX" create/develop a couple of scenarios to illustrate the component parts of the decision matrix as it relates to the reality of relapse.

3. Introduce the concept of "FIRE DRILL STRATEGIES" which are defined as:
   
   A) A routine series of steps put into action immediately should trouble be imminent.
   B) An automatic protection (insurance) plan.

   The success of a fire drill strategy depends on:
   
   A) A clear alarm or clear sign of trouble.
   B) The ability to identify very concrete steps to be taken by the individual.
   C) A routine/regular way to practice the component parts of the fire drill.

4. Using the blackboard or easel pad, engage the group in a brainstorming exercise of listing elements of fire drill strategies that could be employed regularly.

5. Using the "RELAPSE PREVENTION PROGRAM II" discuss each of the items on the plan to ensure all residents have an understanding of what is expected on the plan.

 ASSIGNMENT:

Handout "RELAPSE PREVENTION PROGRAM II" announcing it is to be turned in within one week. Review of each plan will be done by the facilitator and reviewed with the Sexuality Team to determine any additional strategies that may be needed in dealing with individual resident information contained on each of the plans.
REFERENCES


