G.I.R.L.S: Getting Into Real Life Sexuality
An Adolescent Group for Healthy Sexuality

A Graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling
Marriage and Family Therapy

By

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December 2015
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DEDICATION

This project is dedicated to my family, especially to my mom, Maria Luisa Hoyos. She has been one of my biggest supporters and whom without which I would never have been able to receive my education.

A special dedication to my partner, Marc David Ward, whom has been my pillar of strength.

Lastly, I would like to dedicate this project to all of the adolescent girls around the world who need a group to help them embrace their sexuality and make healthy life decisions.
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ABSTRACT

G.I.R.L.S: Getting Into Real Life Sexuality
An Adolescent Group for Healthy Sexuality

By

Jennifer Floyd
Master of Science in Counseling,
Marriage and Family Therapy

Teens in the United States are “far more likely to give birth than in any other industrialized country in the world. U.S teen are two and a half times as likely to give birth as compared to teens in Canada, around four times as likely as teens in Germany or Norway, and almost 10 times as likely as teens in Switzerland” (Kearney & Levine, 2012, p.141). Not only are there high teen pregnancy rates but every year “nine million new STIs occur among teens and young adults in the United States (“Facts on American teens,”” 2012, para. 10). Sexuality education is necessary to protect public health by lowering the rates of STIs and teen pregnancies. There is also a need for a more comprehensive sex education program that offers more than just facts and education materials about pregnancy, STI’s and safe sex practices. The purpose of this project was to develop a ten week comprehensive sexual educational program for adolescent girls.
ages 13-14 years old. In this group they will learn sexual responsibility and general sex
health by addressing cultural and societal barriers, sexual orientation, self-esteem, healthy
relationships, self pleasure, abstinence, and pregnancy/sexually transmitted infections
preventions.
CHAPTER 1: INTRODUCTION

Introduction

The general field of study for this project is to develop a ten week comprehensive sexual educational program for adolescent girls ages 13-14 years old, called G.I.R.L.S: Getting Into Real Life Sexuality. In this group they will learn sexual responsibility and general sex health by addressing cultural and societal barriers, sexual orientation, self-esteem, healthy relationships, self pleasure, abstinence, and pregnancy/sexually transmitted infections preventions. Not only will this project offer education regarding all these topics it will provide support for the group members from the leader as well as with each other. This program will facilitate open discussions where the members can process their thoughts and beliefs by telling their stories so that they feel heard.

Background of the Problem

Our sexuality is vital to who we are and it affects how we express ourselves. There is a diverse range of how people experience their sexuality. For example, some people are very sexual, while others experience no feelings of sexual attraction at all. Although people have different levels of sexual attraction every person has thought and desires, which is why it is important to run a group to explore these thoughts and feelings. A person’s sexuality may be influenced by one’s “family, culture, religion, media, friends, and experiences” (“Sex and Sexuality,” 2014, para. 2). Sexuality encompass such a vast array of concepts that encompass more than just sex. Sexuality includes one's sexual and reproductive anatomy including one's biological sex of being born as male,
female or intersex. Sexuality encompasses one's gender identity of one's sense of being a girl, boy, woman, man, transgender, or genderqueer. Sexuality includes one's sexual orientation of who one is sexually attracted to. Sexuality also consists of one's sexual behaviors including masturbation (“Sex and Sexuality,” 2014, para. 3). Seeing how sexuality affects many parts of our lives and is such a big part of who we are there needs to be a comprehensive sexual education program.

Our school systems are in need of an adolescent girl's healthy sexuality group as teens in the United States are “far more likely to give birth than in any other industrialized country in the world. U.S teen are two and a half times as likely to give birth as compared to teens in Canada, around four times as likely as teens in Germany or Norway, and almost 10 times as likely as teens in Switzerland” (Kearney & Levine, 2012, p.141). Not only are there high teen pregnancy rates but every year “nine million new STIs occur among teens and young adults in the United States (“Facts on American teens,”” 2012, para. 10). Sexuality education is necessary to protect public health by lowering the rates of STIs and teen pregnancies. Currently there are abstinence-only programs and comprehensive sex education programs, which neither possess enough information regarding healthy sexuality.

Abstinence-only programs believe that teaching students to say no to intercourse until marriage is the most effective way to reduce adolescent intercourse, adolescent pregnancy rates and the spread of sexually transmitted infections (Roleff, 2001). Although abstinence is 100% effective for preventing transmitting an STI and preventing
pregnancy, abstinence is often unrealistic as many adolescent's do not want to wait to have intercourse until marriage. In addition, abstinence-only programs instill fear, shame and guilt, which can have lasting effects on adolescents and their self-esteem and self-worth. Lastly, abstinence-only are not effective as one study showed that it “not only did not increase the number of young people who abstained, but, in one school, actually resulted in more students having sexual intercourse after having participated in the course” (Roleff, 2001, p. 140-141).

On the other hand comprehensive sexual education programs are effective for giving adolescents the skills to delay their involvement in sexual behaviors. Comprehensive sexual education programs emphasize safe sex including birth control (condom use in particular), STI prevention, various sexual options, and the advantages of abstinence. Several reviews regarding sexuality education found that it does not encourage adolescents to start having sexual intercourse. It also found that the programs need to begin prior to adolescents experimenting with sexual behaviors to delay sexual intercourse, adolescents who have intercourse after taking the program are more likely to use contraceptive methods and HIV programs that use cognitive and behavioral skills training demonstrate positive results (Roleff, 2001). As shown comprehensive sexual education programs are more effective for preventing pregnancy, preventing STIs and, delaying sexual intercourse than abstinence-only programs.

Although comprehensive sexual education programs are more effective “knowledge alone is not enough to change behaviors. Programs that rely mainly on
conveying information about sex or moral precepts—how the body's sexual system functions, what teens should and shouldn't do—have failed” (Roleff, 2001, p. 149). In order for a program to be successful it should “focus on helping teenagers to change their behavior—using role playing, games, and exercises that strengthen social skills” (Roleff, 2001, p. 149). Lastly, experts have identified characteristics of effective sex education. These characteristics include:

- Offer age- and culturally appropriate sexual health information in a safe environment for participants; are developed in cooperation with members of the target community, especially young people; assist youth to clarify their individual, family, and community values; assist youth to develop skills in communication, refusal, and negotiation; provide medically accurate information about both abstinence and also contraception, including condoms; have clear goals for preventing HIV, other STIs, and/or teen pregnancy; focus on specific health behaviors related to the goals, with clear messages about these behaviors; address psychosocial risk and protective factors with activities to change each targeted risk and to promote each protective factor; respect community values and respond to community needs; rely on participatory teaching methods, implemented by trained educators and using all the activities as designed. (McKeon, 2006)

As demonstrated there is a need for a more comprehensive sex education program that offers more than just facts and education materials about pregnancy, STI’s and safe sex practices. A comprehensive sexual education programs needs to encompass more than
abstinence-only and contraception methods. A comprehensive program should include sexual identity and other forms of healthy sexual experiences such as masturbation, self-esteem, etc.

Statement of Problem

Seeing as there is a need for more comprehensive sexual education programs for adolescents this healthy sexuality group will address all the additional topics that are not currently being taught in sex education programs. Thus, the group members of G.I.R.L.S will be informed and educated on all aspects of human sexuality in hopes of answering any questions and dispelling myths that they may have. By educating these girls on healthy sexuality they will become comfortable talking about sex and sexuality and will be able to make more informed decisions in regards to their sex life with the hopes of lowering STIs and adolescent pregnancy rates.

Purpose of Project

The purpose of this project is to promote sexual health. According to Bekaert (2005) sexual health is:

An important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human right to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease. (p. 86) In addition to promoting sexual health the purpose of the group is to provide a safe space
where these adolescent girls can openly discuss often embarrassing, uncomfortable or taboo topics such as cultural and societal barriers, sexual orientation, self-esteem, self-pleasure (masturbation), sexual activities with a partner, sexual anatomy, abstinence, pregnancy, adoption, abortion, sexually transmitted infections, contraceptive methods, safe sex, healthy relationships, and communication skills. Within each session there will be some psychoeducation, showing of videos and pictures that are relevant to each session, and group activities to foster group cohesiveness and spark interest.

**Terminology**

**Adolescence:** begins after the onset of puberty and ends when the person achieves “adulthood.” It is our emotional and cognitive reactions to puberty (Carroll, 2007). For the purposes of this project adolescence refers to ages 13-14.

**Gender Identity:** gender is the behavioral, psychological, and social characteristics of men and women (Carroll, 2007). Thus gender identity is “one's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth” (“Sexual orientation and gender,” 2015).

**Sexuality:** encompasses who were are as sexual beings. It includes our body parts, gender identity, gender roles, sexual orientation, and our body image. Sexuality includes our sexual experiences, thoughts, ideas and fantasies. It is an integral part of who we are (Sexuality Resource Center for Parents).

**Sexually Transmitted Infections (STIs):** infection that is transmitted from one
person to another through sexual contact. STIs use to be called sexually transmitted disease (STD) (Carroll, 2007).

*Sexual Orientation:* the gender(s) that a person is attracted to emotionally, physically, sexually, and romantically (Carroll, 2007).

**Summary**

The following chapter includes an extensive literature review that explores female adolescent development, sexual identity development, narrative therapy including interventions, group orientation and group activities. Chapter Three discusses the technicalities of the project. The information includes the development of the project, the intended audience, personal qualifications for the persons intended to run this group, the environment and equipment needed to implement this project, a formative evaluation of how to get feedback from professionals to help construct the project, and lastly the outline of the actual project. In Chapter Four, recommendations for implementation and future research are discussed as well as the limitations of the project. Finally, the Appendix consists of a curriculum for a adolescent girls' healthy sexuality group called G.I.R.L.S (Getting Into Real Life Sexuality). In addition to the curriculum, handouts are provided as a reference and guide for the group leader as well for the group leader to give to the participants.
CHAPTER 2: REVIEW OF THE LITERATURE

Introduction

Sexuality education is necessary to protect public health by lowering the rates of STIs and teen pregnancies, however, according to Mueller et al. (2008) focusing solely on the risks and dangers of sex and sexuality leaves a void wherein young people are not provided the tools to develop agency around their sexual needs and desires. Thus, there is a need for a group where more than just education about STIs and pregnancy is provided.

There is also a need for a sex education program that is not abstinence only because as proven in Abstinence Only and Comprehensive Sexual Activity and Teen Pregnancy, abstinence-only programs had “no significant effect in delaying the initiation of sexual activity or in reducing the risk for teen pregnancy and STD” (Kohler et al., 2008, p. 349). Abstinence-only programs fail to teach teenagers safe sex and how to prevent pregnancy and sexually transmitted infections. By withholding accurate information about safe sex that teens need in order to make informed choices, abstinence-only programs deny teens life-saving information.

In contrast, comprehensive sex education programs "reduce the risk for teen pregnancy without increasing the likelihood that adolescents will engage in sexual activity" (Kohler et al., 2008, p. 351). As seen in these articles, there is a need for more sex education programs that encompass not only abstinence and contraception methods but also sexual identity and other forms of healthy sexual experiences such as
Female Adolescent Development

Adolescence is a time when many physical, cognitive, and emotional changes are occurring. Adolescence begins after the onset of puberty and ends when a person achieves adulthood. Puberty is “a period of physical development accompanied by dramatic increases in the circulating levels of many hormones (Susman et al., 1987, p.114). For most girls puberty can begin from the ages of eight and continue until age 13.

Adolescence is divided into three stages: early (ages 12 to 13), middle (ages 14-16) and late (ages 17 to adulthood). During early adolescence, preteens are establishing relationships with their peers and are beginning to separate from their family (Carroll, 2007). Friendships are vital to the adolescent girl’s emotional well-being as they rely on their friends for support and validation during this difficult time. In this stage dating often begins, which “drives many adolescents to become preoccupied with their bodily appearance and to experiment with different ‘looks’” (Carroll, 2007, p. 227). As a result of focusing on their body image, girls may start to diet or develop eating disorders in the hopes of achieving a “perfect” body. Adolescent dating occurs along a “continuum typically progressing from involvement in mixed-sex peer group activities in early adolescence to group dating to finally dyadic dating outside of the group later in adolescence” (Friedlander et al., 2007, p. 822). Parental monitoring as well as peer pressure correlate with dating behaviors. Adolescent's whose parents where not as involved and had lower levels of parental monitoring correlated with higher rates of early dating (Friedlander et al., 2007). The peer group has an influence on early dating as
adolescents model peer behavior in the hopes of fitting in. Adolescent's also value the advice from their peers will and will often engage in their advice to gain their approval (Friedlander, 2007). Thus adolescent's will enter into early dating to get approval from their peers to fit in.

In the middle stage of adolescent development, dating is further explored as relationships are lasting longer in length and sexual experimenting begins, such as kissing and fondling (Carroll, 2007). Gay and lesbian teens may feel out of place during this dating time and feel like they do not belong and may hide their feelings, which can led to depression, loneliness, drug and alcohol abuse, and suicide. In the following subsections early and middle adolescence will be further explored through the discussion of physical, cognitive, and emotional development.

Sexual Activities

As previously stated adolescence is a time of sexual exploration and experimentation. Sexual activity occurs during this exploration. Sexual activity is any voluntary sexual behavior we do. Some common sexual activities are masturbation, kissing on the mouth, with tongue, on body parts, touching a partner's nipples, breasts, or sex organs, sex talk such as phone sex, cybersex, sexting, “talking dirty” during sex, rubbing bodies together with or without clothes (dry sex), oral sex (blow job, eating out, sixty-nine), anal intercourse, and vaginal intercourse (“Understanding Sexual Activity,” 2014).

Kissing and touching are the “first sexual contact that most people have with
potential sexual partners...73% of 13-year-old girls and 60% of 13-year-old boys had kissed at least once” (Carroll, 2014, pgs. 232-233). Oral sex among adolescents is more prevalent than sexual intercourse as “1 in 4 virgin teens (those who had never engaged in intercourse) between the ages of 15-19 report having engaged in oral sex” (Carroll, 2014, p. 233). Many of these adolescents believe that oral sex is a safer alternative that will allow them to maintain their virginity status (Carroll, 2014). Anal intercourse rates are increasing in adolescents as they believe it too allows them to maintain their virginity status. In the United States, 63% of adolescents have had sexual intercourse by their 18th birthday with the average age being 16.9 years old (Carroll, 2014). In addition, “12% of males and 3% of females engage in sexual intercourse by the age of 12” (Carroll, 2014, p. 235).

Masturbation

Masturbation is the erotic stimulation, especially of one's own genital organs commonly resulting in orgasm and achieved by manual or other bodily contact exclusive of sexual intercourse, by instrumental manipulation, occasionally by sexual fantasies, or by various combinations of these agencies (“Masturbation,” 2015). Although masturbation is the most underreported sexual behavior in adolescence, while entering adolescence masturbation increases sharply as it is directed toward achieving orgasm (Carroll, 2007). In addition to wanting to achieve orgasm, people masturbate for sexual pleasure to learn about or better understand their bodies, as a release, to substitute for
partner sex and general sexual dissatisfaction (Bowman, 2014).

There are many ways for females to masturbate. The most common forms of masturbation are using vibrators, sex toys such as dildos, fingers for clitoral stimulation, and penetration with fingers or toys. Lubrication can be used to increase pleasure and protect against irritation. To get aroused women sometimes watch porn, read a romance novel or erotica literature, or use their imagination (“Masturbation,” 2014). Some common feelings women have regarding masturbation are shame, sexual empowerment (powerful, strong, sexy, independent, satisfied), and fear that one is acting selfishly (Bowman, 2014). Research has shown that women who masturbate tend to have “higher self-esteem and a more positive body image. There is also evidence to suggest that masturbation correlates with better sexual functioning overall” (Bowman, 2014, p. 365).

Some other benefits of masturbation are it reduces stress, releases sexual tension and provides sexual pleasure, increases self-esteem and improves body image, helps people learn how they like to be touched and stimulated sexually, and it increases the ability to have orgasms (“Masturbation,” 2014). Considering that 60-65% of women masturbate and seeing all the benefits of masturbation, masturbation should be viewed as a normal, productive and healthy behavior (Bowman, 2014).

**Physical Development**

One of the first noticeable characteristics of puberty is the physical changes that occur in a girls’ body. For most girls puberty begins between the ages of 8 and 13 reaching menarche at the average age of 12 (Carroll, 2007). Although the mean age for
menarche is 12 years old there are some racial differences as non-Hispanic black girls enter into menarche first, followed by Mexican American girls and lastly white girls (Chumlea et al., 2003). The first signs of puberty are the:

Beginnings of breast buds, the appearance of pubic hair, the widening of the hips, and the general rounding of the physique. Increased estrogen levels stimulate the growth of the breasts, labia, and clitoris; the enlargement of the uterus; widening of the vaginal canal; an increase in body fat and in the activities of the sweat glands. (Carroll, 2007, p.224)

In addition to these changes menarche, the first occurrence of menstruation, occurs. Depending on how their culture explains it, menarche can be seen as an exciting, fearful, or shameful experience for adolescent girls (Carroll, 2007). With all these new physical changes occurring girls can have a wide range of emotions such as feeling embarrassed, scared, shameful, sad, excited, happy, etc. These emotions will further be discussed in the next section of emotional development in adolescent girls.

**Emotional Development**

During adolescence the rise of hormone levels at puberty can cause disturbances in an adolescent girl’s emotional states. These disturbances may “reflect disequilibrium in biological processes that may stem from the rapidity of change in hormone levels” (Susana et al., 1987, p. 115). With the change in hormone levels, adolescents will go through a wide range of intense positive and negative emotions. One of the negative emotions is depression as “one-third to one-half of adolescents at any point in time report
significant depressed mood or affective disturbances which could be described as ‘inner turmoil’ or feeling miserable” (Spear, 2000, p. 429). It is no wonder that adolescents are experiencing depression as there are multiple life changes co-occurring such as school changes, body changes, and beginning to date. According to Spear this “buildup of daily stressors/hassles has been reported to be more important than major life events as sources of risk for emotional/behavioral problems in adolescence, with the number of negative life events and not their nature lined to depression in adolescent females” (Spear, 2000, p. 429).

**Self-Esteem**

Recent research by Steinberg and Morris has shown that early-maturing girls in Westernized cultures emphasize the importance of physical attractiveness. Westernized cultures, through the use of advertisement, instills in adolescent females that they are to look a particular way in order to be considered beautiful. Therefore, adolescent girls suffer at high rates of emotional problems, low self-image, higher rates of depression, anxiety, and disordered eating than their peers (Steinberg & Morris, 2001). Early-maturing girls are also more likely to be popular as they receive more attention, especially from older boys, due to their breasts maturing at an earlier rate. These relationships with older boys have a negative influence as early-maturing girls become involved in delinquent activities, use drugs and alcohol, have problems in school, and experience early sexual intercourse (Steinberg & Morris, 2001). In the next section, cognitive development will be addressed.
Cognitive Development

During adolescence the mind is developing rapidly and drastically. Adolescence is the time period during which individuals acquire abstract thinking. Abstract thinking is “thinking characterized by the ability to use concepts and to make and understand generalizations, such as of the properties or pattern shared by a variety of specific items or events” (Dictionary.com, 2015, para. 1). Although adolescents abstract thinking is more developed they tend to engage in risky behaviors and make risky decisions. A reason for this may be that the “decision making capacity of adolescents may be more vulnerable to disruption by the stresses and strains of everyday living than that of adults” (Spear, 2000, p.423).

When discussing adolescence two important psychologists that are often discussed are Sigmund Freud and Erik Erikson. Freud was the first who “saw the relationship between past and present, who first articulated developmental models that shaped symptoms and behaviors, and who first assumed that there was even something called an unconscious life” (Berzoff, Flanagan, & Hertz, 2011, p. 20). Freud introduced a genetic model of psychosexual development to understand how normal child development is shaped by two drives of sexuality and aggression. He believed that when these drives arise in the body they become conscious and seek expression (Berzoff et al., 2011). Within each of the five stages there are “regressions (or returns) to earlier stages of functioning, and there can be fixations (getting stuck) at each stage of development, which may form the basis for pathological relationships or character traits in later life”
Freud also believed that each phase of child development is shaped by an:

- Erogenous zone (a physical zone of sexual pleasure), a drive, an object (usually a person) toward whom the drive is aimed, the psychosexual issue that the individual faces at that stage of development, the cluster of character traits that emerge at each juncture of childhood development, and the kinds of symptoms that might occur at each stage of development. (Berzoff et al., 2011, p. 32)

The stage that pertains to adolescence is the genital stage. In this stage boys and girls are maturing and becoming aware of their bodies. In the cognitive realm, adolescents may have sexual and aggressive feelings that can interfere with their learning or can enrich their curiosity and creativity (Berzoff et al., 2011). Freud believed that during this stage sexually charged feelings towards siblings, peers, and adults begin to emerge. The goal of the adolescent stage is to separate from the family of origin, which is oftentimes achieved by acting out and exhibiting rebellious behaviors (Berzoff et al., 2011).

Although Freud was a pioneer in developing his epigenetic principles from drive theory, Erik Erikson was the first to develop a truly psychosocial theory that is coupled with principles of ego psychology to build on Freud’s already existing theory.

As mentioned above, Erik Erikson is an ego psychologist who theorized that the “ego itself is shaped and transformed, not only by biological and psychological forces but also by social forces” (Berzoff et al., 2011, p.97). Erikson’s greatest contribution to the field is his epigenetic stages that show how people change and continue to grow
throughout their lifetime. Erikson’s adolescent stage of identity vs. role confusion is particularly useful in gathering a further understanding of adolescents. In this stage, adolescents ages 11 to 18 years old are in a crisis as they are trying to “achieve a stable sense of self, which must fit with an image of the individual’s past, present, and future of larger possibilities” (Berzoff et al., 2011, p. 108). In this stage adolescent’s are struggling as they are exploring their identity. If the adolescents are not supported in “forming coherent identities through their personal strengths and societal supports,” they risk developing negative identifications or prematurely stopping the development of their identity (Berzoff et al., 2011, p. 109).

**Sexual Identity Development**

Sexuality is a general term for the “feelings and behaviors of human beings concerning sex” (Carroll, 2007, p. 2). Sexuality is very complex and confusing. It encompasses so many aspects of human traits such as gender identity and sexual orientation.

**Gender Identity**

Gender is a key aspect of sexuality and is a process that begins early in life and heightens in adolescence. According to Carroll, gender is the “behavioral, psychological, and social characteristics of men and women” (2007, p. 65). Gender plays a big role in one’s sexual identity development, as gender roles are established by one’s culture. Gender roles are “culturally defined behaviors that are seen as appropriate for males and females, including the attitudes, personality traits, emotions, and even postures and body
language that are considered fundamental to being male or female in a culture” (Tolman, Striep, & Harmon, 2003, p. 5).

There are many theories as to what influences gender, also known as gender role theory (Carroll, 2007). According to evolutionary theory, gender differences occur from our adaptation to our environment (Carroll, 2007). Gender roles can be learned from our environment, which is known as social learning theory. From a young age, children learn to model their behavior after the same-gender parent and they learn gender-appropriate behavior as many parents reward that behavior and punish gender-inappropriate behavior (Carroll, 2007). Cognitive development theory assumes that children go through a “universal pattern of development, and there really is not much parents can do to alter it” (Carroll, 2007, p. 80). In the beginning of development, children form strict stereotypes of gender based on their observed differences. However, as a child matures, they become more aware of gender roles being arbitrary thus decreasing the child’s rigid gender roles. Gender schema theory suggests that from the time we are born information about gender is presented to us by family, friends, media, etc. (Carroll, 2007). The last theory is gender hierarchy, which are the differences in how men and women are treated based on their gender. In the past as well as in many societies today women’s roles are often considered to be inferior to those of men. This may be due to the fact that masculine traits are more valued than feminine traits.

Society tends to be binary and divide ideas and concepts into two categories. This binary system even occurs with gender and is known as sex typing. Sex typing splits the
world into male and female categories (Carroll, 2007). Although this is not the case as there are so many more variations of genders besides masculine and feminine. These variations include androgyny, transgenderism, transsexualism, third genders, and asexuality.

Masculinity refers to male traits such as strong, logical, independent, confident, etc. Femininity are female traits such as nurturing, patient, empathetic, etc. Until the 1970’s it was believed that the more masculine one was the less feminine one was and vice versa. If a person has high levels of both masculine and feminine characteristics they are androgynous. Transgenderism occurs when a person is “living full or part time in the other gender’s role and derive psychological comfort in doing so” (Carroll, 2007, p. 86). Within the transgender community there are transsexuals, transvestites, drag queens, and female impersonators. Someone who is transsexual feels trapped in the body of the wrong gender. A transvestite is a person who receives sexual pleasure from dressing in the clothing of the other gender. A drag queen is typically an actor who is a gay man who performs in flamboyant women’s clothing. A female impersonator is a male actor who dresses in women’s clothing for many reasons. Many cultures reject and challenge the American binary categories of gender. One such culture is the Native American society as they have a category known as berdaches, which is a third gender who takes on the social role of the other gender, also known as two-spirit (Carroll, 2007). The final gender category is asexuality, which is when a person has a lack of sexual desire or has a lack of maleness or femaleness (Carroll, 2007).
Gender roles have begun to change especially in modern American society, although this change can cause confusion, fear, and hostility. According to Carroll (2007), gender roles exist because they “allow comfortable interaction between the sexes. If you know exactly how you are supposed to behave and what personality traits you are supposed to assume in relation to the other sex, interactions between the sexes go more smoothly” (p. 76).

**Sexual Orientation**

Just as gender is vital to one’s sexuality, sexual orientation also plays a crucial role in adolescent’s sexual identity development as it determines to whom one is physically, sexually, romantically and emotionally attracted to (Carroll, 2007). Sexual orientation is comprised of many categories and many different labels but the main three categories are people who identify as heterosexual, homosexual, and bisexual. Although these three categories are the main focus it is important to know that the “full variety and richness of human sexual experience, however, cannot be easily captured in such restrictive categories. People show enormous variety in their sexual behavior, sexual fantasies, emotional attachments, and sexual self-concept, and each contributes to a person’s sexual orientation” (Carroll, 2007, 328). The three main categories will be discussed below.

A person who identifies as heterosexual is a man or woman who is sexually attracted to members of the other sex (Carroll, 2007). Someone who identifies
themselves as homosexual, are attracted to members of the same sex. A person who is
bisexual is attracted to members of either sex.

Sexuality is not black and white, straight or gay. It is on a continuum, which is
based on Kinsey’s 7-point scale. Kinsey’s continuum is based on heterosexual and
homosexual behaviors. The seven points on his scale are: exclusively heterosexual (0),
predominately heterosexual/incidental homosexual (1), predominately heterosexual/more
than incidental homosexual (2), equally heterosexual and homosexual (3), predominately
homosexual/ more than incidental heterosexual (4), predominately homosexual/incidental
heterosexual (5), exclusively homosexual (6) (Carroll, 2007). Although Kinsey was a
pioneer in sexual orientation, his scale was flawed in that it emphasized people’s
behavior and the scale is static in time (Carroll, 2007).

Another important model is the Klein sexual orientation grid, which took
Kinsey’s continuum further by including seven dimensions. The dimensions are
attraction, behavior, fantasy, emotional preference, social preference, self-identification,
and lifestyle (Carroll, 2007). These dimensions are measured for the past, present, and
the ideal as it determines whether the dimensions have changed over time and it looks at
a person’s fantasy of his or her ideal sexual orientation.

**Sexually Transmitted Infections**

Sexually Transmitted Infections (STIs) are infections that are transmitted from
one person to another through sexual contact. STIs use to be called sexually transmitted
diseases (STDs) (Carroll, 2007). According to the Centers for Disease Control and
Prevention in the United States, roughly 20 million new STIs occur among men and women between the ages of 15-24 ("Reported STDs," 2014, para. 3). In addition, chlamydia had the highest number of cases reported at 1.4 million cases ("Reported STDs," 2014, para. 4). What is especially alarming is that many adolescent females do not believe they are at risk for contracting STIs even though they are at a higher risk for developing an STI as their cervix is more vulnerable than an adult women's cervix (Carroll, 2007). Overall, women are more susceptible to “gonorrhea, chlamydia, and HIV, although the spread of syphilis and genital warts is usually shared equally between the sexes” and “women are at a greater risk for long-term complications from STIs because the tissue of the vagina is much more fragile than the skin covering the penis” (Carroll, 2007, p. 496).

STIs are classified into three categories: ectoparasitic infections, bacterial infections, and viral infections. Ectoparasitic infections are caused by parasites that live on the skin's surface. The two ectoparasitic infections are pubic lice (crabs) and scabies. Pubic lice is a “parasitic STI that infests the pubic hair and can be transmitted through sexual contact” (Carroll, 2007, p. 498). Pubic lice can be treated with ointment that comes in a shampoo or cream that kills the insects and eggs. In addition, all clothing, bedsheets and towels must be washed in hot water. Scabies affects the skin as it can cause rashes and itching and is spread during skin-to-skin contact. Scabies are treated with topical creams and all clothing, bedsheets and towels must be washed in hot water (Carroll, 2007).
The STIs that fall under the bacterial infections are gonorrhea, syphilis, chlamydia, chancroid, trichomoniasis, bacterial vaginosis, vulvovaginal candiasis, and pelvic inflammatory disease (Carroll, 2007). Gonorrhea (the clap or drip) causes a puslike discharge and frequent often painful urination in men, while most women are asymptomatic (without recognizable symptoms). Transmission of gonorrhea occurs when the “mucous membranes come into contact with each other; this can occur during sexual intercourse, oral sex, vulva-to-vulva sex, and anal sex” (Carroll, 2007, p. 500). Gonorrhea can be treated with antibiotics.

Syphilis can be transmitted during sexual contact through small tears in the skin and can be transmitted through the placenta during pregnancy (congenital syphilis) (Carroll, 2007). There are three stages of infection. In the first stage there are chancres (one or more small, red-brown sores) that appear on the vulva, penis, vagina, cervix, anus, mouth or lips. In the second stage reddish patches that look like hives appear on the skin, wartlike growths may appear in the area of the infection, loss of hair may occur, and the lymph glands in the groin, armpit, and neck enlarge and become tender. In the third stage the infection goes into remission. Penicillin is used to treat syphilis (Carroll, 2007).

Chlamydia is the most commonly reported STI in the United States. It is transmitted during vaginal intercourse, oral or anal sex (Carroll, 2007). Chlamydia can be asymptomatic although female symptoms include burning during urination, pain during sexual intercourse, and pain in the lower abdomen. Male symptoms include
discharge from the penis, burning sensation during urination, burning or itching around
the opening of the penis and pain or swelling in the testicles. Antibiotics are used to treat
chlamydia (Carroll, 2007).

Chancroid are small bumps that rupture and form painful ulcers (Carroll, 2007). Chancroids are treated with antibiotics. Trichomoniasis is a vaginal infection that results
in discomfort, discharge, and inflammation. Bacterial vaginosis (BV) can cause vaginal
discharge and odor but is often asymptomatic. Vulvovaginal candidiasis (yeast infection)
causes burning, itching and a heavy discharge. This infection is caused by different fungi
present in the vagina and multiplies when the pH balance of the vagina is disturbed due to
antibiotics, regular douching, pregnancy, oral contraceptive use, diabetes or careless
wiping after defecation. Treatment includes an antifungal prescription or over-the-counter
drugs. The last infection is pelvic inflammatory disease (PID), which is an infection of
the female genital tract caused by Chlamydia trachomatis and Neisseria gonorrhoeae.
PID can cause fever, vaginal discharge, infertility, chronic pelvic pain, and ectopic or
tubal pregnancies. PID is treated with antibiotics (Carroll, 2007).

Viral Infections consist of herpes, human papillomavirus (HPV), viral hepatitis,
human immunodeficiency virus (HIV), and acquired immune deficiency syndrome
(AIDS) (Carroll, 2007). Herpes is caused by herpes simplex virus (HSV). Herpes
simplex I (HSV-1) cause cold sores on the face or lips and herpes simplex II (HSV-2)
causes genital ulcerations. Herpes simplex I and II can be spread through vaginal
intercourse and anal sex. It is possible for people with HSV to reinfect themselves
(autoinoculate) by by touching on open lesion and then rubbing another mucosal area. Although there is no cure for herpes, antiviral drugs are used to shorten the duration of outbreaks (Carroll, 2007).

HPV can cause genital warts and or cervical cancer. HPV can be transmitted through sexual intercourse, oral sex, vulva-to-vulva sex or anal sex (Carroll, 2007). The treatment for HPV are chemical topical solutions, cryotherapy (freezing the warts with liquid nitrogen), electrosurgical interventions (removal of warts using a hot wire loop), or laser surgery. Viral hepatitis is caused by impaired liver function and is split into three types: hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV). HAV is transmitted through fecal-oral contact and is spread by food handlers. HAV symptoms include fatigue, abdominal pain, loss of appetite and diarrhea. HAV is treated with vaccines. HBV is spread through high-risk sexual behaviors. HBV is usually asymptomatic but can cause nausea, headaches, and fever. HBV is treated with vaccines. HCV can be spread through sexual behavior as well as illegal intravenous drug use or unscreened blood transfusions. HCV is usually asymptomatic as well. There are currently no vaccines for HCV (Carroll, 2007).

HIV is the retrovirus responsible for the development of AIDS and can be transmitted through bodily fluids, including semen, vaginal fluid, breast milk, and blood, during vaginal or anal intercourse, and through intravenous drug use by sharing needles. AIDS is a condition of “increased susceptibility to opportunistic diseases; results from an infection with HIV, which destroys the body's immune system” (Carroll, 2007, p. 516).
HIV never goes away and when the body is weakened from HIV and can no longer fight disease, the body can become infected with AIDS. HIV is a gradual deterioration of the immune system. Some symptoms include significant weight loss, severe diarrhea, night sweats, oral ulcers, fever, blurred vision. HIV is treated by highly active antiretroviral therapy (HAART), which is a combination of three or more HIV drugs (Carroll, 2007).

**Pregnancy**

According to Bekaert (2005), United States of America has the second highest pregnancy rate for women aged 15-19 in the developed countries (p. 48). In addition, teenage contraception rates are higher in “deprived areas of the country compared with affluent areas. These areas are characterized by poor levels of education and poor job prospects” (Bekaert, 2005. p. 48). These high pregnancy rates are high due to low expectations, ignorance and mixed messages. Young people have low expectations when they have been disadvantaged in childhood and have poor expectations of education or the job market. The ignorance occurs when young people lack accurate knowledge of contraception, STIs, relationships, and being a parent. Mixed messages occur when young people are “surrounded by sexually explicit material yet adults generally do not talk openly about sex and protection, resulting in unprotected sex” (Bekaert, 2005, p. 49-50).

Pregnancy is the period from conception to birth. One becomes pregnant when the egg is fertilized by a sperm and then implanted in the lining of the uterus where it develops into the placenta and embryo and later into fetus. Pregnancy usually lasts for 40
weeks and is divided into three trimesters, each lasting roughly three months (Carroll, 2007).

Throughout the pregnancy women experience many changes such as morning sickness (nausea and vomiting), sensitivity to odors, food cravings, fatigue, breast tenderness, constipation, heartburn, increased urination, increase in appetite, ankle or leg swelling, hemorrhoids, increases in varicose veins, sleep problems, and increased or decreased sex drive. In addition, during this time women's hormonal levels are fluctuated thus women go through a range of emotions such as excitement, happiness, and anxiety (Carroll, 2007).

According to Carroll (2007) the majority of women go through pregnancy without any problems. Although since pregnancy is a complex process some problems can arise. Some problems include ectopic pregnancies, spontaneous abortion (miscarriage), chromosomal abnormalities, Rh incompatibility, and toxemia. It is important to note that in order to have a healthy pregnancy nutrition and light exercise are recommended. In addition, nicotine, alcohol, drugs, and caffeine are strongly recommended to avoid as they can cause physical or mental deficiencies, low birth weight, and spontaneous abortion (Carroll, 2007). After looking at the stages and changes of pregnancy, contraception will now be discussed.

**Contraception**

There are many different forms of contraception also know as birth control, which is the “prevention of pregnancy by abstinence, or the use of certain devices or surgical
procedures to prevent ovulation, fertilization, or implantation” (Carroll, 2007, p. 407).
The forms of birth control include; barrier methods, hormonal methods, chemical
methods, intrauterine methods, natural methods, permanent methods, and emergency
contraception. Barrier methods such as condoms and caps prevent the sperm from
entering the uterus. Hormonal methods consist of synthetic hormones that change
hormonal levels to interrupt the production of ova to prevent fertilization and
implantation. The hormonal methods include the pill, the ring, and the patch. Chemical
methods including spermicides, which come in creams, gels, foams, suppositories, and
films, that work by reducing the survival of sperm in the vagina. Intrauterine methods
such as the intrauterine device (IUD) and the intrauterine system (IUS), are small plastic
devices that are inserted into a woman's uterus. Natural methods consists of fertility
awareness, withdrawal, and abstinence all of which “do not alter physiological function”
(Carroll, 2007, p. 433). Permanent (surgical methods) consists of female and male
sterilization. The last form of contraceptive methods is emergency contraception.

The condom is a “latex, animal membrane, or polyurethane sheath that fits over
the penis and is used for protection against pregnancy and sexually transmitted infections;
polyurethane female condoms, which protect the vaginal walls, are also available”
(Carroll, 2007, p. 411). Not only do condoms protect against pregnancy but they also
provide protection from STIs. Latex and polyurethane condoms are 85% effective for
typical use and 98% effective for perfect use whereas female condoms have a 79%
effectiveness for typical use and 95% effectiveness for perfect use. In addition to
preventing STIs some other advantages of condoms are that they are relatively inexpensive and they do not require a prescription. Although condoms are proven effective some of the disadvantages are that some may feel a reduced sensation or feel slightly uncomfortable if the condom is the wrong size or if they are allergic. Lastly, condoms may tear if there is not enough lubrication (Carroll, 2007).

The next barrier method is the diaphragm, which consists of a latex dome on a flexible spring rim that fits over the cervix and can be used with spermicidal cream or jelly (Carroll, 2007). After intercourse the diaphragm must be taken out after 6 or 8 hours but never more than 24 hours. The effectiveness rates are 84% for typical use and 94% for perfect use. Advantages for the diaphragm are no hormonal levels and it is inexpensive. The disadvantages are that a physician's prescription and appointment are needed, there is an increase risk of toxic shock syndrome, urinary tract infection, and postcoital drip, as well as it can develop a bad odor if left in place too long (Carroll, 2007).

Another barrier method is the contraceptive polyurethane sponge, which is impregnated with spermicide and is inserted into the vagina (Carroll, 2007). The effectiveness rates are 75% for typical use and 89% for perfect use. The advantages of a contraceptive sponge are that no prescription is needed, they do not affect hormonal levels, and once inserted sexual intercourse can occur multiple times within 24 hours. Some disadvantages are that the contraceptive sponge may increase risk of toxic shock syndrome and urinary tract infections, can leave a bad odor if left in place too long, can
become expensive if used frequently, can be difficult to insert and remove, and men may feel uncomfortable as they may feel the sponge (Carroll, 2007).

The last barrier method are cervical barriers, which are plastic or rubber covers for the cervix; that provide a contraceptive barrier to sperm (Carroll, 2007). The two types of cervical barriers are Femcap and Lea's Shield. The effectiveness for typical use is 86%. The advantages are no hormonal effects, and it can be left into place for 48 hours. The disadvantages are it can increase the risk of toxic shock syndrome, urinary tract infections, postcoital drip, and vaginal odors. Some other disadvantages are that it needs to be fitted by a healthcare provider and can cause discomfort during intercourse (Carroll, 2007).

The hormonal method that will be discussed first is the combined-hormone birth control pills. The combination birth control pill is an oral contraception that contains synthetic estrogen and progesterone. Birth control pills work as they thicken the cervical mucus, which inhibits the mobility of sperm and the hormones prevent the pituitary gland from sending hormones to cause the ovaries to begin maturation of an ovum. The pill usually are taken on a “21-day or 28-day regimen and started on the 1st or 5th day of menstruation or on the 1st Sunday after menstruation” (Carroll, 2007, p. 423). In the 28-day pack there are seven placebo pills that are sugar pills, used as reminder pills. The pill is the most commonly used contraceptive method in the United States and the effectiveness rates are 92% for typical use and 99.7 for perfect use. For the pill to be effective it is extremely important for the pill to be taken every day at the same time of
day. The advantages of the pill are that it is extremely effective if taken correctly, it reduces menstrual flow, menstruation cramps, premenstrual syndrome, facial acne, ovarian cysts, and uterine and breast fibroids. The disadvantages are that the pill does not protect against STIs, can be expensive, can decrease its effectiveness if used with certain other medications, and should not be taken if a person smokes as it can increase a heart attack (Carroll, 2007).

The next hormonal method is the hormonal ring (NuvaRing), which is a “small plastic contraceptive ring that is inserted into the vagina once a month and releases a constant dose of estrogen and progestin” (Carroll, 2007, p. 426). The effectiveness rates are 99.7% but can be lower when used with other medications. The advantages are that it has a high effectiveness rate, reduces the flow of menstruation, menstrual cramps, and premenstrual syndrome. It also can provide protection from ovarian and endometrial cancer. The disadvantages are that the NuvaRing does not protect against STIs, can cause weight gain or loss, breast tenderness, nausea, mood changes, changes in sexual desire, and increased vaginal irritation and discharge (Carroll, 2007).

The hormonal patch (Ortho Evra patch) is a “thin, peach-colored patch that sticks to the skin and time-releases synthetic estrogen and progestin into the bloodstream to inhibit ovulation, increase cervical mucus, and render the uterus inhospitable; also referred to as the 'patch’” (Carroll, 2007, p. 427). With perfect use the effectiveness rate is 99.7% but the patch becomes less effective in women who weigh more than 198 pounds. The advantages are high effectiveness rate, reduces menstrual flow, menstrual
cramps, and premenstrual syndrome. It also protects against ovarian and endometrial cancer and ovarian cysts. The disadvantages are that the patch does not protect against STIs, can cause weight gain or loss, breast tenderness, nausea, mood changes, changes in sexual desire, and increased vaginal irritation and discharge (Carroll, 2007).

The progestin-only birth control methods consist of minipills (pill that contains only synthetic progesterone and no estrogen), subdermal contraceptive implant (implant that time-releases a constant dose of progestin to inhibit ovulation), Norplant (uses doses that are implanted in a woman's arm and that can remain in place for up to 5 years), and hormonal injectables (Depo-Provera), which prevents ovulation and thickens cervical mucus) (Carroll, 2007). The effectiveness of the mini pills are 92% for typical use and 99.7% for perfect use. For subdermal implants the effectiveness is 99.95% for the first year of use and rates decrease after the third year. The effectiveness for Depo-Provera is 97% for typical use and 99.7% for perfect use. The advantages for subdermal implants are that they are effective, long-lasting, and have no estrogen side effects. The disadvantages are that insertion costs are expensive, users may experience irregular bleeding, acne, nausea, headaches, weight gain or loss, general weakness, scars after the removal of implant, and pain during removal. The advantages of Depo-Provera is it is highly effective, one injection lasts for 3 months, it is moderately expensive, reduces risk of endometrial and ovarian cancer, decreases cramping, users usually have lighter periods and 30-50% of users have no menstrual periods. The disadvantages are the user must go to the doctors office for the injection every 3 months, and injections can cause irregular
bleeding. Some other side effects are fatigue, headaches, appetite increase, increase in cervical, liver and breast cancer, and decrease in bone density (Carroll, 2007).

The chemical method consists of spermicides, which have an effectiveness rate of 71% for typical users and 82% for perfect use (Carroll, 2007). The foam is more effective than jelly, cream, film or suppositories. The advantages are that it is easy to use, does not require a prescription, provides lubrication during intercourse, and there are no serious side effects. The disadvantages are that it may be expensive depending on frequency of intercourse, may cause allergic reactions, may cause vaginal skin irritations, and may increase urinary tract infections (Carroll, 2007).

The intrauterine methods consist of IUDs and IUSs, which are inserted by a healthcare provider and create a “low-grade infection of the uterus, which may interfere with sperm mobility and block sperm from passing from the Fallopian tubes and joining with an ovum” (Carroll, 2007). The effectiveness rates range from 99.2-99.9%. The advantages are that they are the least expensive method over time, and it decreases menstrual flow. The disadvantages are that they do not protect against STIs, may cause irregular bleeding, increase risk of uterine perforation, and users with multiple sexual partners are at an increased risk of pelvic inflammatory disease (Carroll, 2007).

The first natural method that will be discussed is natural family planning, which involves calculating ovulation and avoiding intercourse during ovulation by using the rhythm method and fertility awareness method by calculating the basal body temperature. The effectiveness is 75% for typical use and 99% for perfect use. The advantages are
that is is acceptable form of birth control for religious reasons, is inexpensive, and has no side effects. The disadvantages are that it does not protect against STIs, has low effectiveness rates, and women who have irregular cycles may have a hard time interpreting their charts (Carroll, 2007).

Another natural method is withdrawal, which occurs when the penis is withdrawn from the vagina during ejaculation. The effectiveness rates are 73% for typical use and 96% for perfect use. The advantages are that it is an acceptable method for religious reasons, it is free, and has no side effects. The disadvantages are that it does not protect against STIs, can be stressful for both partners, men might find it difficult to withdraw their penis before ejaculation, and has low effectiveness rates (Carroll, 2007).

The last natural method is abstinence, which is not engaging in sexual intercourse. This method is 100% effective, protects against some STIs, and is used for religious reasons. The disadvantage is that this may be too difficult to abstain from sexual intercourse for some people (Carroll, 2007).

Permanent methods include female and male sterilization. Female sterilization, also known as tubal sterilization, is a “surgical procedure in which the Fallopian tubes are cut, tied, or cauterized, for permanent contraception” (Carroll, 2007, p. 436). Male sterilization, also known as vasectomy, is a surgical procedure for permanent contraception where the vas deferens are cut, tied, or cauterized. The effectiveness of both procedures range from 99-99.9%. The advantages are that they are highly effective, has a quick recovery, and have few long-term side effects. The disadvantages are that
surgery is required, it can be expensive, it provides no protection from STIs, and must be considered irreversible (Carroll, 2007).

The last form of contraceptive is emergency contraception (EC), which prevents pregnancy after unprotected vaginal intercourse. The two forms of EC are levonorgestrel pills (Plan B, also known as the morning after pill) and paraguard IUD insertion (“Morning-After Pill,” 2014). Each form can be used up to 120 hours after unprotected intercourse. The morning-after pill is 89% effective when taken within 72 hours of unprotected intercourse and becomes increasingly less effective the longer one waits to take the pill. The paraguard IUD is 99.9% effective (“Morning-After Pill,” 2014). The advantages of the morning-after pill are that it does not require a prescription and it is easy to use. The disadvantages are that it is controversial, it has many side effects that can last for 1-2 days such as nausea, vomiting, cramping, breast tenderness, headaches, and abdominal pain (Carroll, 2007). The advantages of paraguard IUD is that is highly effective and can be left in for up to 12 years. The disadvantages are that it is expensive for the initial insertion, and does not protect against STIs (“Morning-After Pill,” 2014).

There are many different forms of contraceptive methods differing in effectiveness rates and advantages as well as disadvantages. Each individual considering a birth control method will have to pick the right method for them. The next section will discuss abortion, which is a very controversial issue.

**Abortion**

In 2000, one-third of pregnancies among 15 to 18 year olds was terminated
through abortion. Abortion is the procedure that terminates a human pregnancy. Abortions can be performed as either first- or second-trimester procedure. The first-trimester abortion occurs within the first 14 weeks of pregnancy. The procedures that are used are vacuum aspiration, using suction to empty the contents of the uterus. The second-trimester abortion occurs between the 14th and 21st weeks of pregnancy. There are multiple procedures that are used during the first and second-trimester. Dilation and evacuation (D&E) is used, which involves cervical dilation and vacuum aspiration of the uterus. Another procedure is induced labor procedure, which uses drugs to start labor. Saline abortion is a procedure in which amniotic fluid is removed and replaced with a saline solution causing premature delivery of the fetus. Hysterotomy is another abortion procedure that surgically removes the fetus through the abdomen. Lastly, there are medical abortions which use medicine (Mifepristone, RU-486, Methotrexate) to end a pregnancy. These procedures involve risks such as uterine perforation, cervical laceration, severe hemorrhaging, infection, and anesthesia-related complications, which can increase the risk of death (Carroll, 2007).

Not only do women undergo physiological side effects from having an abortion but women also go through psychological effects. These effects are separated into three categories; positive emotions, socially based emotions, and internally based emotions. Positive emotions include relief and happiness. Socially based emotions include shame, guilt, and fear of disapproval. Lastly, internally based emotions include regret, anxiety, depression, doubt, and anger. Many women cycle through these reactions. If the
woman's negative psychological effects are severe it is important for them to seek support and help from her friends, family, healthcare provider and therapist (Carroll, 2007).

The reasons women have abortions are that they believe that a baby would interfere with their education or career goals, the inability to provide financially for a baby, difficulties with the father, not wanting people to know that they are sexually active, pressure from their partner or family, fetal deformity, risks to the mother's health, having several children already, rape or incest. This decision is very complex and difficult (Carroll, 2007).

This is a controversial issue as some people believe that abortion should be illegal. These people are known as pro-life supporters and they believe that human life begins at contraception thus an embryo is a person and an abortion is murder. Pro-choice supporters are on the other side of the issue as they believe that personhood does not begin at conception and that the decision to have an abortion should be left up to the women and should not be regulated by the government (Carroll, 2007). Abortion is also controversial as in the United States, “states determine specific laws concerning mandatory parental notification or parental consent for an abortion for daughters under the age of 18. Many states have mandatory parental consent or reporting laws” (Benson, 2004, p. 442). The states with mandatory parental notification can make it more difficult for teens wanting an abortion as they may be thrown out of the house or may be unable to get an abortion if the parent prevents them from doing so. Other than abortion, adoption may be another option for unwanted adolescent pregnancies.
Adoption

After a woman becomes pregnant she can choose to keep the baby, have an abortion, or she can place the infant for adoption. Adoption consists of legally giving up parental rights and responsibilities over to another person or persons. This is usually done through adoption agencies as a traditional closed adoption (no communication between biologic and adoptive parents) and open adoption which consists of four levels: restricted open adoption, semi-opened adoption, full open adoption, or continuing open adoption.

A restricted open adoption occur as “arrangements are made for pictures and information about the child's development to be sent periodically to the birthparents for a specified time following placement. Adopters sign an agreement to furnish the material, and the adoption agency serves as the post office” (Demick & Warner, 1988, p. 229). A semi-opened adoption are when the birthparents meet the people who will be adopting the child, but no identifying information is shared. A full open adoption occurs when both sets of parents meet and share information. Lastly, a continuing open adoption occur when the “birth-parents and adoptive parents establish a plan for continuing contact with one another and the child over the course of the child's development. It is assumed that open adoption differs from closed adoption in that, in the former, adoptive parents will at some point share this information with the adoptee” (Demick & Warner, 1988, p. 229).
Some reasons that adolescent's may choose adoption are not feeling prepared to be a parent, which can be a result of lack of familial support, or lack of financial support. In addition, the adolescent may have higher educational aspirations, pressure from the significant people in their life, and wanting to provide a better life for their child may play a role in choosing adoption for their baby. When the decision is made some adolescents may feel sadness, and regret (Benson, 2004).

Any decision comes with pros and cons and will be difficult to make. Although the woman may have many familial, partner, religious, or societal pressures it is ultimately up to the woman to make the right decision for herself as it is her life. After looking at adoption, healthy relationships will be discussed.

**Healthy Relationships**

Healthy relationships are subjective and can include different components for different people. Although it is subjective there a few important skills that we can develop to enhance our ability to form “healthy” relationships including self-love, receptivity, affection, trust, respect, and listening.

Self-love is love for one's self. It is vital to accept our faults as well as our positive qualities to promote our own well-being. Once we are able to love ourselves rather than look to others for validation to find our self-worth then we will be able develop a deeper intimacy with another person (Carroll, 2007).

Receptivity is being receptive to others. Receptivity can be communicated by eye contact, smiling and through relaxed body language. By utilizing receptivity this allows
us to be approachable and it makes another person to feel more comfortable. Engaging in receptivity will help improve the relationship as it will ignite a reconnection, which will preserve intimacy and passion (Carroll, 2007).

Affection consists of acts such as hugging, kissing, etc. Most people want to experience affection from their partner as affectionate acts show that “you feel a sense of warmth and security with your partner” (Carroll, 2007, p. 204). Affection thus creates a sense of connectedness, which is important in a relationship.

Trust is very important in any relationship. Trust can take time to develop and can be hard for many people as they might have been betrayed in the past. Also if people have an issue with giving up control trust can be difficult because by trusting someone you are ultimately giving them the benefit of the doubt and the power to hurt or disappoint you. Trusting behaviors “lead to greater trust in the relationship and more confidence that the relationship will last. When a couple trusts each other, each expects the partner to care and respond to his or her needs, now and in the future” (Carroll, 2007, p. 204).

Respect is vital to a relationship. Each person enters a relationship with a different set of wants, needs, and beliefs than our own. Even when we do not share the same sentiments it is important to respect them by acknowledging and understanding their needs (Carroll, 2007).

Listening is the key to fostering good communication. Listening shows that you care about another person as you demonstrate that they have your full attention. In
addition, listening shows that you are hearing their wants and needs. Listening thus enhances intimacy (Carroll, 2007). Listening falls into the category of communication skills, which are very important in a healthy relationship. Seeing the importance of communication, communication skills will be reviewed in depth in the next section.

**Communication Skills**

According to Carroll (2007), “good communication is the hallmark of a healthy, developing relationship...communication fosters mutual understanding, increases emotional intimacy, and helps deepen feelings of love and intimacy” (p. 159). Many relationship problems “stem from misunderstandings and poor communication, which lead to anger and frustration” (Carroll, 2007, p. 159). Seeing as communication is vital to a healthy relationship being an effective communicator is important. There are many techniques to help become a more effective communicator.

Some communication techniques include giving helpful and supportive feedback by listening to understand what the other person is trying to say and what they want you to respond with such as simply lending an ear to listen or giving them advice. It is important not to wait until one is angry and discuss one issue at a time to prevent bigger fights. It is important to let go of the need to be right and to ask questions to truly understand the other persons needs, desires and thoughts. Being direct on ones needs is helpful as the other person cannot read minds. Being supportive by praising the other person is also important. Another technique is to learn to forgive and not continuously bring up the past. Some communication patterns to avoid are overgeneralizations (using
always or never), name-calling, yelling, stonewalling (refusal to speak when upset) and overkill (one person threatens the worst but doesn't mean it).

The last important communication patterns that are encouraged are taking turns talking, non-defensive listening (focusing attention on what the other person is saying without becoming defensive), active listening (using nonverbal communication, such as nodding, to let the other person know that they are listening), come to a compromise or understanding, and use I-statements (Carroll, 2007). I-statements are “declarative sentences that describe a thought, feeling, or other experience in a singular first person manner” (Burr, 1990, p. 266). I-statements allow the individual to take responsibility for their feelings and reactions. I-statements are also much more likely to be heard as they minimize blame and defensiveness (Burr, 1990). An example of converting a You-statement to an I-statement is “You make me furious” to “I'm furious.”

Up until this point in the literature review many aspects of female adolescent development has been addressed such as sexual activities, masturbation, physical development, emotional development, self-esteem, and cognitive development. Sexual identity development, gender identity, sexual orientation, sexually transmitted infections, pregnancy, contraceptions, abortion, adoption, healthy relationships, and communication skills have also been discussed. In the next section narrative therapy, group orientation, group activities and interventions will be reviewed.

**Narrative Therapy**

Narrative therapy was developed in Australia and New Zealand by Michael White
and David Epston. According to Gehart (2013), narrative therapy has five main treatment phases where “we ‘story’ and create the meaning of life events using available dominant discourses—broad societal stories, sociocultural practices, assumptions, and expectations about how we should live” (p. 399). People begin to have problems when their personal life does not match these dominant discourses. Thus, narrative therapists help people separate the person from the problem and look at the relationships that people have with their problems (Combs & Freedman, 2012). By separating the person from the problem this allows the person to recognize different ways they can act in their day to day lives. Helping clients enact their preferred realities and identities is the main goal in narrative therapy.

Narrative therapy has five main treatment phases. The first is meeting the person where the therapist gets to know the client as separated from their problem. The therapist finds out what interests and hobbies the client has. The second phase is listening, where the therapist listens for the effects of dominant discourses and finds exceptions where there wasn't a problem. The third phase is separating the person from the problem, where the therapist externalizes the problem to create space for the client’s new identity to appear (White, 2007). The fourth phase is enacting preferred narratives, where the therapist helps the client find new ways to relate to the problem to reduce the negative effects that the problem has on the client and all the people that the problem effects. The fifth and final stage is solidifying, where the client’s preferred stories are witness by someone important in the client’s life (Gehart, 2013). Solidifying can be done through
The therapeutic relationship is an important aspect of narrative therapy. Within the relationship the therapist gets to know the client apart from their problem, which makes them feel like a human being. The therapist then separates the person from the problem as the main motto in narrative therapy is “the problem becomes the problem, not the person” (White, 2007, p. 26). By externalizing the problem this enables the client to create their own identity. By getting to know the client apart from the problem and focusing on their strengths, the therapist provides optimism and hope. In addition to providing hope, therapists believe that all people are resourceful and that people do not have problems, the problems were imposed on them by damaging societal cultural practices (Gehart, 2013). In narrative therapy the therapist is a co-author and co-editor as they help the client to construct meaning in the clients life and create a “better” story. By re-authoring conversations this invites people to “continue to develop and tell stories about their lives, but they also help people to include some of the more neglected but potentially significant events and experiences that are 'out of phase' with their dominant storylines,” which are called unique outcomes or exceptions (White, 2007). Unique outcomes are stories where the problem-saturated story does not play out in its usual way and they are used to help the client tell a more accurate story of their own identity. Lastly, the therapist is also an investigative reporter and instead of trying to fix the problem immediately the therapist “uses a calm but inquisitive stance to explore the origins of problems and thus to inspire clients to develop a better understanding of their larger contexts” (Gehart, 2013, p. 403).
Another important part of narrative therapy is the assessment. During the assessment the therapist is listening to the client’s problem-saturated stories, which are stories where the problem “plays the leading role and the client plays a secondary role, generally that of the victim” (Gehart, 2013, p. 403). While listening to the story the therapist listens about how the problem affects the client at an individual level as well as a relational level. While assessing the client it is vital to look at the dominant and local discourses. Dominant discourses are societal stories of how life “should” happen, which create problems as these “shoulds” are informing the perception of the problem. Local and alternative discourses do not conform to dominant discourses as they have a different set of “shoulds” that occur in the client’s heads. It is important to look at local and alternative discourses as they provide a “resource for generating new ways of viewing the self and for talking and interacting with others around the problem” (Gehart, 2013, p. 404). This is especially vital for this group as the leader can tap into the teen culture and understand their worldview and values. The leader can also explore how their alternative discourses can co-exist with the dominant discourse.

There are many interventions in narrative therapy, to name a few, there are externalizing, permission questioning, situating comments, and letters and certificates. Externalizing involves conceptually and linguistically separating the person from the problem by changing the description adjective into a noun. An example of externalizing is changing from a client is schizophrenic to the client is having a relationship with Schizophrenia. Permission questioning are questions that therapists use to ask a question.
Permission questions would work well in this group as the topic matter is at times uncomfortable. Thus, a good permission question may be “would it be okay if I ask you some questions about your sex life?” Permission questions emphasize the democratic relationship to show that the therapist is not the expert. Situating comments also enforce the democratic therapeutic relationship as the comments that are said by the therapist emphasize that it is just one perspective and that their comments are not more valid than the clients. This intervention would be useful in this group as it would reinforce the self-agency of participants. The last intervention that will be discussed are letters and certificates. Letters were used to further develop the clients preferred narratives and identities by writing the client’s emerging story and reinforcing new preferred behaviors. Certificates help the clients identify the changes that they have made and they reinforce the clients new reputation and gives the client physical validation in the form of a certificate (Gehart, 2013).

**Group Orientation**

There is much research on the effectiveness between group and individual therapy and according to Yalom and Leszcz (2005) there is evidence that group therapy is at least as efficacious as individual therapy and has many benefits as it is “superior to individual therapy in the provision of social learning, developing social support, and improving social networks” (p. 232). Thus, the group format would allow the girls to hear different perspectives and feel like they are not alone. They can bond over their sharing of stories and lean on each other for support.
The theoretical orientation that will be used for the interventions is narrative therapy. This type of therapy allows the leader to get to know the participants separate from their problems, listen to their dominant discourses, separate the participant from the problem, enact preferred narratives and solidify. By helping the participants become aware of how their different discourses impact their lives, “this awareness increases client’s sense of agency in their struggles, allowing them to find ways to more successfully resolve their issues” (Gehart, 2013, p. 400). By helping participants to externalize their problems this creates space for new identities and stories to emerge, thus giving the participant the opportunity to “enact their preferred realities and identities” by giving the participants the power to direct their lives in they want it to go (Gehart, 2013, p. 404). Lastly, solidifying helps participants strengthen their preferred stories and identities by having them witnessed by important people in the participant’s lives.

The participants will benefit from narrative therapy as it will allow them to tell their own story from their own perspective. It will also challenge their dominant discourses, which will be particularly important for this group as there will be multiple ethnicities and cultures. Since this group is open to different sexual orientations, narrative therapy will work well as this therapy helps “deconstruct the heterosexist discourses that are often the source of the greatest suffering in the GLBTQ clients” (Gehart, 2013, p. 422).

There are many helpful interventions in narrative therapy but two that will be used during the group are problem deconstruction: deconstructive listening and questions and
situating comments. Leaders use problem deconstruction to help the participants “trace the effects of dominant discourses and empower clients to make more conscious choices about which discourses they allow to affect their life” (Gehart, 2013, p. 408). In deconstructive listening, the leader will “listen for ‘gaps’ in clients’ understanding and asks the to fill in details or has them explain the ambiguities in their stories” (Gehart, 2013, p. 408). In deconstructive questioning the leader helps participants analyze their stories to see how they have been constructed by identifying the influence of dominant and local discourses. These questions address problematic beliefs, practices, feelings, and attitudes by asking the clients to identify the history of the relationship, the contextual influences, the effects or results of the problematic belief, the interrelationship with other beliefs and the strategies used by the problematic belief (Gehart, 2013).

The second intervention that will be used is situating comments, which are used to establish a democratic relationship to enforce client agency. To promote a democratic relationship the leader will “situate their comments by revealing the source of their perspective, emphasizing that it is only one perspective among others” (Gehart, 2013, p. 411). Once the leader has disclosed their context of their comment this will ensure that the leader’s comments are not more important or valid than the participants.

**Group Activities**

There will be an array of fun and interesting activities to facilitate learning and to keep the group interested. One activity will be the “baseball” and “pizza” models (Vernacchio, 2013). The baseball model helps people make decisions about initiating or
participating in sexual activities to clarify their own values about the purposes and goals of sexual activities. The pizza model uses more positive terms and offers potential for “healthy, fulfilling, pleasurable, and safer sexual activity” (Vernacchio, 2013, p. 81).

After discussing both models and the terms associated with each, the group will fill out a handout to figure out if they are the baseball or pizza model. Once the handout is completed there will be discussion questions and processing will take place.

In addition to the baseball/pizza activity, there will be sentence-completion exercises to “generate interest and energy among members because members are usually curious about how other members have responded to the same sentence stems” (Jacobs et al., 2012, p. 224). A few examples of sentence-completions that are discussed in Group Counseling: Strategies and Skills are “I think sex is ___,” “Many of my feelings about sex come from ___,” or “I would like to have sex ___” (Jacobs et al., 2012, p. 225). These sentence-completion exercises are important as they focus discussion on member’s thoughts and feelings about sex.

Another activity that will be used is dyads in which participants split off into pairs to discuss specific topics and issues. The use of dyads is valuable according to Jacobs et al. (2012) as it develops comfort between the participants since talking in pairs is less intimidating than speaking in front of a group. Dyads also warms the members up to start thinking about particular topics and helps them brainstorm together so they can later share their ideas and thoughts with the larger group. By engaging in dyads this allows the participants a break from the traditional format, which can be a refreshing
Another benefit to dyads are that it can either bring two participants that have a lot in common together so they can further relate to one another or it can bring two participants who don't feel comfortable with each other to talk things out in hopes of decreasing the discomfort (Jacobs et al., 2012).

Yet another activity that would work well for this group is the STD/HIV handshake. The purpose of this activity is to increase awareness of how quickly HIV and other STDs can be spread (“STD/HIV handshake,” 2008). The procedure is to hand out index cards with the secret instructions on them to each participant. Each card has either a C, O, Z or X on them. The leader will ask the group to shake hands with three people and have them sign each card. Once the participants have collected the signatures the leader will ask the people with O, Z, and X on their cards to stand up and everyone who shook their hands to stand up. The leader will then tell the group that the person with the card with a Z on it was infected with HIV and that instead of shaking hands with those three people that person had unprotected sex with them. The leader will do the same thing with the people who have O (chlamydia) and X (genital herpes) on them. Then have the participants with the C on the cards stand and explain that they had safe sex and used a condom so they were not at risk for infection. The leader will then explain all the different ways STDs are spread and provide descriptions of each STD. In addition, the leader will provide the telephone number for the STD hotline. Lastly, the leader will allow time afterwards to discuss how the participants felt about either being a C, Z, O, or X and the impacts that this game might have in their future (“STD/HIV handshake,”
2008).

**Additional Interventions**

Two interventions that are discussed in *Relationships Between Adolescent Sexual Risk Behaviors and Emotional Self-Efficacy* that have shown success in sexual risk reduction for adolescents are Social Learning Theory and/or Social Cognitive Theory (Valois et al., 2013). Within these theories some successful interventions “incorporate the use of peer educators; modeling through activities such as role play that help adolescents recognize stimuli that trigger unsafe sexual behaviors; and cognitive rehearsal for enhanced confidence in initiating safer-sex conversations; negotiating safer sex; and skills for refusing unsafe sexual encounters” (Valois et al., 2013, p. 49).

Another successful risk reduction intervention, according to Valois et al. (2013), are condom demonstrations designed to enhance condom application skills and techniques for effective partner communication as well as condom negotiation to increase self-efficacy for safer sexual behavior. Both of these interventions would be extremely useful in this group as the participants would be able to practice these skills so that they will feel comfortable and confident when they actually need to have the safe talk or use a condom in the future.

**Conclusion**

The relevance of chapter two is to demonstrate the need for this group through a brief literature review. This literature review discussed early and middle adolescence including physical, cognitive and emotional development. This review also explored
gender identity and sexual orientation. The activities that will be incorporated into the group are included as well. In addition, narrative therapy was discussed as it would be a good theoretical orientation to use as it allows the participants to tell their story and give them the opportunity to change their preferred identities. In the next chapter the project will once again be introduced. Chapter three will discuss the development of the project, the intended audience, the personal qualifications of the group provider, the environment where the group will be held, the equipment that will be used, the formative evaluation, and the project outline of the content of the group will be included.
CHAPTER 3: PROJECT AUDIENCE AND IMPLEMENTATION FACTORS

Introduction

This project is an educational, support, and self-growth group designed for 13-14 year old adolescent girls. The group format will employ multiple layers as it will be psycho-educational to provide adolescent girls accurate information on many topics including pregnancy, STIs, masturbation, contraceptive methods, etc. This group will also be one of self-growth as the participants will be expanding their ideas about how sexuality impacts their everyday life and how this concept will change them. They will be learning who they are as a sexual being as they learn to embrace their body and sexuality. Not only will the group participants be learning about their body anatomically, but they will become aware of their body image and be able to gain self-esteem. Lastly, this group will be a support group as it will be a place where the participants can share their feelings, thoughts, and stories with the group and be able to connect with their peers.

Development of Project

The beginnings of this project started out as an assigned paper for a group proposal for a Graduate Studies class. The student was interested in writing about a group for adolescent girls’ healthy sexuality. The student was interested in this particular group as she was working with many adolescent girls who had low self-esteem and did not have enough knowledge regarding their sexual health. The student thus wanted to make a curriculum to run a group in which adolescent girls could learn about their bodies, their sexual health, and have a place where the girls could feel heard, and
After the paper was written the student decided to turn that paper into her project for her Graduate Project. The student met with her project chair multiple times to discuss her vision for her project and receive feedback of what her project should include. After the multiple meetings the student did extensive research using books, and online articles and journals to write the literature review as well as designing the curriculum for the group.

**Intended Audience**

The target population for the girl’s healthy sexuality group will be from the ages of 13-14. According to Mueller et al. (2008) research suggests that receiving formal sex education before first sex is associated with abstaining from sexual intercourse, delaying initiation of sexual intercourse, and greater use of contraception at first sex. In addition, across the United States in “2005, 34% of 9th graders and 63% of 12th graders reported ever having had sexual intercourse” (Kirby & Laris, 2009, p. 22). Since there are a substantial amount of girls having sexual intercourse around 13 years and older, it is important that they receive proper education early on in hopes of delaying first intercourse to when these girls are more emotionally mature and ready to take that step.

This age group was also chosen as the girls will be more mature and able to have more in-depth discussions but at the same time young enough before many of them will be fully sexually active. The level of education on the subject matter is important as well. If an individual knows too much about the topic she may become bored but if she knows...
practically nothing she may disrupt the group as she may have too many questions or may need more explaining and attention that may take away from the rest of the group.

The potential group participants will be screened by the group leader performing personal interviews. Personal interviews are the best screening method according to Jacobs, Masson, Harvill, and Schimmel (2012) as it “allows the leader to access most easily the appropriateness of the member for the group, and it gives the leader a chance to make contact with potential members” (p.72). Through the personal interview the leader can assess maturity levels as well as educational levels and determine if the individual knows too little or too much about the subject matter. In addition, this screening method gives the leader the opportunity to inform potential group members about the purpose of the group and this gives the potential group member the chance to ask questions to see if the group is a right fit for them.

**Personal Qualifications**

This educational, self-growth, and support group were envisioned for pre-licensed or licensed mental health practitioners, marriage and family therapists, psychologists, or licensed professional counselors who are interested in working with adolescent girls. The above mentioned qualifications are important as the person or persons who will run the group will be using Narrative Therapy and thus should have knowledge of this theory. The pre-licensed or licensed professional must also have knowledge about the female adolescent development, gender identity, and sexual orientation. As there are many “taboo” subjects that will be discussed it is necessary that the group leaders are
comfortable discussing such “taboo” topics and will not show shock when hearing the participants stories in order to avoid the participants from closing up and stopping from sharing. It is vital that the group leader be empathetic, open-minded, and warm to foster a safe environment for the group participants to voice their experiences, concerns and questions. Lastly, the pre-licensed or licensed professional must be careful to avoid any countertransference they might have in regards to their personal opinions regarding the participants sexual experiences as this might cause the group leader to lose sight of the participants’ needs and purpose of the group.

Environment and Equipment

The group will meet once a week after school for 90 minutes. This session length would work well because 60 minutes is too short to cover each topic and at 120 minutes the participants will start lose their attention span. Having each session be 90 minutes allows for each topic to be discussed in depth with time for questions and comments. For best results according to Jacobs et al. (2012) there will be no more than 8 participants in the group. Ideally, group leaders would be commissioned by the school to facilitate the group process.

This group will be closed because new participants would have missed out on the bonding process that occurs in the beginning sessions. It may be too late to build that rapport with the older participants, which will make it harder for the participants to be able to open up and share their experiences with new members and vice versa. It would also be too difficult for a new participant to catch up on all the material if they are not in
the group from the beginning as all the topics are very important. Since the subject matter is so important, attendance is vital. Thus, only one absence is permitted for group members.

This group will be conducted at the school campus. The location requirements are a private room to keep confidentiality, a large enough room to fit all the participants with chairs and some tables. A white board and screen will also be needed to be able to write on the board, to discuss topics, and to show power point slides or videos.

The materials necessary to run the group are a computer to show videos and power points, handouts with important information discussed in group, art materials for the interventions, and props such as condoms and bananas to demonstrate how to correctly use a condom.

**Formative Evaluation**

In order to receive feedback in regards to the construction of this project the student will meet with their project chair, project readers, and the principle and teachers and parents at the school that the group will be held at. In addition, if possible the group leader will meet with a professional who specializes in adolescents and sexuality. The purpose of consulting with various professionals are to get feedback on how to make the group more beneficial an impactful. These meetings will also help manage the potential risks and special considerations associated with doing group therapy with this population.

The first risk may be that parents become upset and may not want their child to participate in such a group. To manage this risk the group facilitator can call the parents
to inform them of the group content and to discuss with them why this group is so valuable and important. By keeping the lines of communication open, the parents will feel included and will be more likely to cooperate. Since the group is not a part of the school curriculum, is an after school program and the participants are over the age of 12 years old, the leader does not need parents to consent on the consent form as the participants can do so for themselves. Although having the parent’s consent and cooperation will be more helpful.

Another potential risk is the participants breaking confidentiality by talking to people outside of the group about other participants in the group, which can cause fights. The group leader will need to make sure to discuss and emphasize confidentiality multiple times during the course of the group. The leader needs to make sure the participants know how important and serious confidentiality is and informing participants that if they break confidentiality they may not be able to stay in the group.

A special consideration associated with this group is having multiple ethnicities and cultures as this can cause disagreements due to their different perspectives and beliefs. Participants who are multiethnic or multicultural may be impacted by racism, and discrimination. These experiences can result in decreased self-esteem, increased stress, feelings of depression, and isolation (Gehart, 2013). Thus multicultural and multiethnic participants may not feel understood by the group. According to Gehart, using a narrative approach can empower multiracial and multiethnic clients and allow those individuals to access the unique strengths inherent in their rich cultural experience.”
(Gehart, 2013, p. 421). To allow the participants to be heard, understood, empowered and united the leader will use narrative strategies such as; inviting the clients to tell their stories, externalizing the problem, probing for unique outcomes, expressing curiosity, reauthoring one's life, telling the new story to an audience, strengthening self-validation, and developing strategies for resistance (Gehart, 2013).

Yet another special consideration would be different sexual orientations within the group. This may make participants feel uncomfortable either from religious or ethnic reasons to just not understanding the LGBTQ community. The group leader needs to once again provide a safe and open space for the participants to discuss their feelings and by doing so the leader can psycho-educate the participants about sexual orientation and the continuum of sexual feelings and attraction. In addition, the leader will need to use narrative therapy to help the LGBTQ participants deconstruct the heterosexist discourses that are often the greatest source of suffering (Gehart, 2013). The leader will then need to help the LGBTQ participants construct positive labels and identify narratives for themselves and their relationships. After identifying their narratives the participants will be able to “live according to their preferred sexual identity, one that is congruent with their lived experience, spiritual beliefs, and cultural values” (Gehart, 2013, p. 424).

**Project Outline**

**Session #1: Introduction to Group**

- Introduction about the group and its purpose.
- Have participants do a brief introduction about themselves.
• Ice breaker of two truths and a lie to help members become acquainted, feel more at ease, and to start building rapport.
• Discuss confidentiality and rules of the group.
• Review and sign consent form.
• Activity- fact or fiction game regarding myths about sex.
• Start to use situating comments and continue to do so throughout all sessions.
• Wrap up and introduce next weeks topic of societal and cultural pressures.

Session #2: Societal and Cultural Pressures

• The leader will use deconstructive listening and questions to discuss societal and cultural pressures about how women “should” behave.
• Facilitate discussion in regards to the stereotypes women receive and what “slut shaming” is.
• Activity- Identify each participant’s dominant cultural discourses as well as local and alternative discourses regarding what sex means to them and their family/culture by doing a sentence completion exercise. Ex: Many of my feelings about sex come from______.
• Wrap up and introduce next weeks topic of sexual orientation.

Session #3: Sexual Orientation

• Discuss the different sexual preferences that people may have as well as all the different aspects of sexuality by showing them the gender bread girl.
• Give out a handout about all the terms that are used in the LGBTQ community.

• Have a guest speaker who is a part of the LGBTQ community come in to share their experience. Allow time for questions and discussion about misconceptions they may have had about the LGBTQ community.

• Wrap up and introduce next week’s topic of self-esteem.

**Session #4: Self-Esteem**

• Show the music video Try by Colbie Caillat to facilitate discussion regarding self-esteem.

• Activity- have participants make two collages out of magazines, one about how they see themselves now and another about how they want to look like or how they want to see themselves.

• Activity- Have each participant write positive traits for each group member on the back of the “present self” collage.

• Discuss how self-esteem ties into one’s sexuality.

• Wrap up and introduce next week’s topic of sexual anatomy and sexual activities.

**Session #5: Sexual Anatomy and Sexual Activities**

• Educate participants in what different sexual body parts look like and how they function.

• Mountain art activity.

• Discuss intercourse as well as different types of sexual activities with a partner.
• Wrap up and introduce next week’s topic of masturbation.

**Session #6: Masturbation**

• Have participants write down what they think masturbation is and what they have heard or been told about it. Leader will read aloud the answers, debunk myths, properly define masturbation, and explain the benefits of masturbation.

• Have participants split off into dyads and have them discuss their feelings regarding the new found knowledge regarding masturbation. Then come back together as a group and discuss.

• Wrap up and introduce next week’s topic of STIs and safe sex.

**Session #7: STIs and Safe Sex**

• Provide education about STIs.

• Activity- STD/STI handshake.

• Educate participants about safe sex practices.

• Activity- use props such as a banana to have the participants practice putting on a condom correctly.

• Wrap up and introduce next week’s topic of pregnancy and birth control.

**Session #8: Pregnancy and Birth Control**

• Give statistics of teen pregnancy.

• Educate about the process of pregnancy including bodily changes.

• Activity- have participants wear a fake belly to feel what it would be like to be pregnant.
• Discuss adoption and abortion.

• Educate participants with the different forms of birth control including the benefits and side effects.

• Wrap up and introduce next week's topic of healthy relationships and communication skills.

**Session #9: Healthy Relationships/Communication Skills**

• Have participants discuss how communication is in their households and with their friends or partners as well as what they like or would want to change about their communication styles.

• Educate on fair fighting rules and “I” statements. Pass out handouts.

• Activity- have participants role play initiating safe sex talks with their partners including their wants and needs.

• Wrap up and discuss what the last session of this group will look like next week.

**Session #10: Closing**

• Discuss and summarize what participants learned and what they will take away from this group.

• Process feelings about ending the group.

• Give certificates and have a graduation ceremony to make participants feel empowered about.

• Wrap up.
CHAPTER 4: CONCLUSION

Summary of Project

Our school systems are in need of an adolescent girl’s healthy sexuality group as teens in the United States are “far more likely to give birth than in any other industrialized country in the world. U.S. teen are two and a half times as likely to give birth as compared to teens in Canada, around four times as likely as teens in Germany or Norway, and almost 10 times as likely as teens in Switzerland” (Kearney & Levine, 2012, p.141). Not only are there high teen pregnancy rates but every year “nine million new STIs occur among teens and young adults in the United States (“Facts on American teens,”” 2012, para. 10). Sexuality education is necessary to protect public health by lowering the rates of STIs and teen pregnancies. There is also a need for a more comprehensive sex education program that offers more than just facts and education materials about pregnancy, STI’s and safe sex practices.

This project is a comprehensive sexual education program designed for 13-14 year old adolescent girls. The group format will employ multiple layers as it will be psycho-educational to provide adolescent girls accurate information on many topics including sexual orientation, sexual activities, pregnancy, STIs, masturbation, contraceptive methods, etc. This group will also be one of self-growth as the participants will be expanding their ideas about how sexuality impacts their everyday life and how this concept will change them. They will be learning who they are as a sexual beings as they learn to embrace their body and sexuality. The members will learn how to have
healthy relationships and this group will help the members with their communication skills. Not only will the group participants be learning about their body anatomically, but they will become aware of their body image and be able to gain self-esteem. Lastly, this group will be a support group as it will be a place where the participants can share their feelings, thoughts, and stories with the group and be able to connect with their peers. The goal of this group is by educating these girls on all the topics encompassing their sexuality they will become more comfortable talking about sex and sexuality and will be able to make more informed decisions in regards to their sex life.

**Recommendations for Implementation**

This project curriculum is a comprehensive program designed to educate adolescent girls regarding their sexuality and to empower them to be in control of their sexuality. It is recommended that the group leader be thorough in reading the literature review as well as the group curriculum in order to be educated and prepared to run this group. In addition, it is recommended that the leader be a qualified counselor or therapist who has experience in working with adolescent girls. The leader should have the ability to present the material, answer any questions that the group members may have, and lead a discussion based on each week’s topics. Lastly, it would be beneficial for the leader to alter any of the activities based on what they feel confident leading as well as based on the needs of the group.

The recommendations for this group to be implemented is at school campuses after school. Having the group run at school campuses is the most convenient for the
group participants as well as their parents. In addition, the participants will be in an academic mindset as they have just finished their normal school day. The location requirements are a private room to keep confidentiality, a large enough room to fit all the participants with chairs and some tables. A white board/chalk board and screen will also be needed to be able to write on the board, to discuss topics, and to show videos.

**Recommendations for Future Research**

Statistics show that comprehensive sexual education programs are much more effective than abstinence-only programs. Most of these programs are of a larger group setting, the average size being that of a class size at a school (roughly 25-30 adolescents). Further research is needed on small single sex education groups and the effectiveness of such courses for the participants. In addition, more specific research is needed on cultural expectations and socioeconomic status regarding sex and child bearing in order to design palatable activities for the adolescent girls. This will foster a sense of connectedness within the group and the leader as well as assist with external factors such as peer pressure, familial structure, and economic woes.

This group incorporated narrative therapy as its base for the interventions that were used. Narrative seemed to be most useful in order for the group members to be able to tell their stories. Future research can look into different forms of therapy other than narrative therapy to integrate into the group to offer different techniques in which to impact the participants on multiple levels.

This group would benefit from including the parents in some shape or form as it
only focused on the adolescent girls themselves. Future research is needed to understand the benefits of having sessions with parents, especially for sessions where healthy relationship and communication skills are discussed. In addition to having parents in sessions with the group members it would be beneficial to consider the impact and implications for having the group leader run a parallel group with the parents. In this group the leader would be explaining to the parents what they are teaching and what activities they are doing with their children. The leader would be educating the parents on how to communicate with their children regarding their sexuality. This group would also be beneficial in that this could be a place where the parents can discuss their concerns, thoughts, and feelings regarding their children growing up and becoming sexually active beings.

Another recommendation for future research would be to administer a pretest and posttest to determine the effectiveness of the group curriculum. During the initial interviewing process for the participants to qualify for the group a pretest will be conducted. This pretest will assess the participants’ knowledge on the group topics. Once the group finishes their last session a posttest will be administered to the participants to determine what they have gained and retained from the experience. The results from the pretest and posttest will help determine which topics and activities were effective. In addition, it would be beneficial to have the participants fill out a survey so as to tailor and adjust the curriculum to meet the participants needs and improve upon their educational experience.
Limitations

This project has a few limitations, the first being that some of the topics may be too large to tackle in a single one and a half hour session. Thus we can expand on these topics into future sessions if the group leaders deems necessary based upon the group’s needs. One topic in particular that may be too large to cover in one session is self-esteem. Many adolescent girls struggle with their self-esteem and may need additional sessions to discuss where their negative self-image came from, to engage in multiple activities that will help increase their self-esteem, and have more time to get support from the group members and leader.

Another limitation is that each set of group members will have a different set of needs. Therefore the group leader may choose to alter sessions by adding relevant coursework or removing coursework per population needs. In addition, the leader may see that additional topics may be important to add. Some topics to include may be how drugs and alcohol can impact one's sexual decision making, and how technology along with sexting is impacting the current adolescent generation.

As the project curriculum is in English this presents a limitation such as only English speakers would be able to understand and effectively run the group. It would be beneficial to have this project be translated into various languages. Spanish would be especially important due to higher pregnancy and STI rates for Latina adolescent girls in the United States. By having this project translated into various languages this will allow multiple cultures to be helped in their native tongue.
Conclusion

Growing up I only had one sex education class and it only covered STIs, pregnancy, and was abstinence-only based mixed with fear based. The teacher terrified me as I thought that I would definitely get an STI or become pregnant if I had intercourse. The teacher also made me feel guilty for engaging in sexual activities and I felt pressured into waiting to have intercourse until marriage. Luckily I had friends and close family members who I was able to talk to regarding my sexuality. Although I had people to talk to it took me many, many years to feel comfortable in my own skin and own my sexuality. Looking back I become upset that I was not able to have a comprehensive sexual education experience that would have helped me grow as a sexual being.

This group was created to help current and future adolescent girls have a safe space where they can talk about their thoughts, feelings, and beliefs. It is my hope that adolescent girls will feel heard, and understood in this group. I want this group to be an all-encompassing sexual education that will help these girls grow and feel empowered as women and confident in their decisions, whatever they may be. My hope would be that this group one day will be incorporated in many schools sexual education programs in the United States. I believe that this group could effectively lower teen pregnancy rates and STIs. This group will also increase self-esteem, foster healthy relationships, and build communication skills.
REFERENCES


Wadsworth.


webster.com/dictionary/masturbation


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Introduction and Purpose of the Group

This project is an educational, support, and self-growth group called G.I.R.L.S, which is designed for 13-14 year old adolescent girls. The group format will employ multiple layers as it will educate these adolescent girls on many topics including societal and cultural pressures, sexual orientation, self-esteem, sexual anatomy, sexual activities, masturbation, STIs, safe sex, pregnancy, birth control, and communication skills. This group will also be one of self-growth as the participants will be expanding their ideas about how sexuality affects their everyday life and how this idea will change them. They will be learning to understand who they are as a sexual being while also embracing their body and sexuality. Not only will they be learning about their body anatomically, but they will become aware of their body image and be able to gain self-esteem. Lastly, this group will be a support group as it will be a place where the participants can share their feelings, thoughts, and stories with the group and be able to connect with their peers.
Note to the Group Leader

How the Participants Will Be Screened

The potential group participants will be screened by the group leader performing personal interviews. Through the personal interview the leader can assess maturity levels as well as educational levels and determine if the individual knows too little or too much about the subject matter. In addition, this screening method gives the leader the opportunity to inform potential group members about the purpose of the group and this gives the potential group member the chance to ask questions to see if the group is a right fit for them.

How the Group Leader Should Prepare

The group leader should prepare for this group by thoroughly reviewing each week's session including the handouts as well as making sure that they have sufficient knowledge regarding narrative therapy, female adolescent development, societal and cultural pressures, gender identity, sexual orientation, self-esteem, sexual anatomy, sexual activities, masturbation, STIs, safe sex, pregnancy, birth control, adoption, abortion, and healthy relationships/communication. The leader should also make sure that they have all the materials needed for each session. Lastly, the group leader needs to prepare themselves mentally and make sure that they are comfortable discussing these “taboo” topics so as not to show shock when hearing the participants stories as this may cause the participants to close up and stop sharing. The group leader needs to be empathetic, open-minded, and warm to foster a safe environment for the group.
participants to voice their experiences, concerns and questions. In addition, the group leader must be careful to avoid any countertransference they might have in regards to their personal opinions regarding the participants sexual experiences as this might cause the group leader to lose sight of the participants’ needs and purpose of the group.

**How the Group Curriculum is Presented**

This group curriculum is broken down into ten sessions, each addressing differing topics. Each session includes: the purpose of the session, the materials needed, the activities that will used during the session as well as the time allotted for each activity, and handouts. Some of the handouts are just for the group leader to use as a reference while other handouts are meant to print out and pass out to the participants to further their knowledge and engage them in the activities.
Session #1: Introduction

**Purpose:**

1. To inform participants of what the group entails including the topics that will be discussed.
2. To help participants build rapport with the leader as well as each other.

**Materials:**

Consent forms. Paper and pens for two truths and a lie game. Masking tape for fact or fiction game. Box, paper and pens for the safe box.

**Activities:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 minutes</td>
<td>1. Introduction about the group and its purpose. See handout A for group leader spiel of the group and its purpose. Group leader will introduce self as well.</td>
</tr>
<tr>
<td>20 minutes</td>
<td>2. Have participants do a brief introduction about themselves. Then have them play the game two truths and a lie.</td>
</tr>
<tr>
<td>10 minutes</td>
<td>a. Participants will write their name as well as two truths and one lie about themselves. The leader will read the cards and everyone will guess which is the lie.</td>
</tr>
<tr>
<td>10 minutes</td>
<td>3. Discuss confidentiality and rules of the group. See handout B. Review and sign consent form. See handout C. Have participants bring the consent home for their parents to sign.</td>
</tr>
<tr>
<td>30 minutes</td>
<td>4. Fact or fiction game regarding myths about sex</td>
</tr>
</tbody>
</table>
a. Leader will put a piece of tape on floor dividing the room into two sections of fact or fiction. After the leader reads out sentence regarding sex the participants will choose a side before the answer is revealed. See handout D for game questions.

5. Wrap up and introduce next weeks topic of societal and cultural pressures.

   a. Leader will process how the first session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn? What are you wanting to get out of this group?

   b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.

   c. Have a closing ritual where the participants will say something that they appreciate about being in group.
Introduction to Group and its Purpose

**Group Leader:** “Hi girls! I’m so excited to run this fun and exciting group with you. I know at first you may feel shy or embarrassed but I hope that after each week you will start to feel more comfortable and be able to talk about anything in this room. This is a safe space and I am not going to judge you. I am here to listen, educate, and support you. Since this is a sex education group some topics may be uncomfortable for you and that is okay. In this group we will be talking about many topics such as societal and cultural pressures, sexual orientation, self-esteem, sexual anatomy, sexual activities, masturbation, STIs, safe sex, pregnancy, birth control, and communication skills. In this group you will be learning to understand who you are as a sexual being. Another main goal of this group is to increase your self-esteem because being a teenage girl is hard. There are so many changes that you are going through both physically and emotionally. With bullying and all the pressure to be perfect it is difficult at times to feel good about yourself. That is why this group will also be a support group. As I mentioned earlier this is a place where you can share your feelings, thoughts, and stories with the group.”
Confidentiality

Group leader: “In this group you can feel free to share anything you want. Everything that is said in this group stays in this group. There are only a few exceptions where I would have to break your confidentiality as I am a mandated reporter. The exceptions are if I hear about any child or elder abuse. If anyone of you are going to hurt another person. The last exception is if you are going to hurt yourself and/or are going to attempt suicide. Does everyone understand the exceptions to confidentiality? Do you need anything explained?”

Standard Rules of the Group

1. Everything that is said in this room stays in this room as everything is confidential.

2. No interrupting when another girl is talking.

3. There will be no name calling or teasing.

4. Everyone will treat everyone else with respect.

Note: These are just a few standard rules for the group. It is recommended that the leader add any rules they feel that is important. In addition it is beneficial to have the participants add a few group rules.
GIRLS’ Group Consent

Client Contract and Consent to Group Counseling

Please indicate your informed consent for group counseling for your child by reading this information sheet and signing below.

**Group Information**
This group is an educational, support, and self-growth group for 13-14 year old adolescent girls. The group format will employ multiple layers as it will educate these adolescent girls on many topics including societal and cultural pressures, sexual orientation, self-esteem, sexual anatomy, sexual activities, masturbation, STIs, safe sex, pregnancy, birth control, and communication skills. This group will also be one of self-growth as the participants will be expanding their ideas about how sexuality affects their everyday life and how this idea will change them. They will be learning to understand who they are as a sexual being while also embracing their body and sexuality. They will become aware of their body image and be able to gain self-esteem. Lastly, this group will be a support group as it will be a place where the participants can share their feelings, thoughts, and stories with the group and be able to connect with their peers.

**Counselor Information**
As a condition of receiving treatment you acknowledge and accept that all counselors are either Marriage and Family Therapist (MFT) Interns or advanced MFT Trainees in graduate programs and work under the supervision of licensed professionals who have ultimate responsibility for the counseling. Counselors will discuss cases in clinical supervision, in either an individual or group setting, with the licensed professional. While services will be rendered in a professional and ethical manner, there are limitations to the type of services and there is no guarantee of specific results regarding counseling goals.

**Limits of Confidentiality**
The group leaders adhere to the confidentiality standards of legal and ethical counseling practice. This confidentiality agreement extends between the client and the group leader and can include issues around sexuality, abuse, and substance use. There are exceptions to confidentiality, however, which arise from certain California legal mandates. These exceptions are:

The necessity of reporting to authorities, without the client’s consent, information which may indicate the presence of child abuse, elder abuse, neglect or endangerment, physical, emotional, or sexual in nature. When it appears that the client, or a person known to the client, intends to hurt another person, the Intern or Trainee has a duty to warn the intended
GIRLS’ Group Consent

victim and the police authorities; and when it appears evident that the client will most probably make a suicide attempt, appropriate steps shall be taken to prevent such an attempt.

In each of the above cases, an attempt will be made to inform the client/guardian when a report will be made. The client will also be encouraged to be involved in making the report.

Consent to Treatment
The undersigned client, or the parent/legal guardian if the client is a minor, requests, consents, and authorizes the group leaders to perform all counseling services which may be deemed advisable or necessary. According to the laws of the State of California, a minor at least 12 years of age can consent to outpatient mental health treatment under certain conditions including but not limited to the following:

The mental health care provider believes the minor is mature enough to consent to treatment and the minor would present a danger of severe physical or mental harm without treatment.
The minor is a victim of incest or child abuse.
The minor is seeking treatment for drug/alcohol related problems, communicable and sexually transmitted diseases, or conditions caused by rape and sexual assault.
The minor may consent in certain situations where requiring parental consent might discourage the minor from receiving necessary care and treatment.

Agreement
Each of the undersigned acknowledges that he/she has read and understands the foregoing provision and that the person signing as agent, parent, or personal representative certifies that he/she is lawfully entitled to act on behalf of the client.

I have read and fully understand all of the above terms and conditions and agree to abide by this contract as a condition of receiving services by the group leader.

Client’s Name (Please Print)

Client Signature Date

Legal Guardian Signature (If Client is a Minor) Date
Legal Guardian/Parent Name (Please Print)

Counselor Signature                     Date

Supervisor Signature                   Date

**Note:** This consent form was adapted from the Mitchell Family Counseling Clinic.
<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
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<tbody>
<tr>
<td>1. Most teenagers have had sexual intercourse by the time they finish high school.</td>
<td>Fiction: 30% off girls and 50% of boys have had sexual intercourse by age 17.</td>
</tr>
<tr>
<td>2. A girl can become pregnant before she has her first period.</td>
<td>Fact: Before a girl’s first period, her ovaries release the first ovum (egg), during ovulation. She can become pregnant if she has intercourse around the time of her first ovulation.</td>
</tr>
<tr>
<td>3. A teenager has to be 18 to get contraception from a clinic, without a parent’s consent.</td>
<td>Fiction: In all states but Utah, teens of any age can get contraception without a parent’s consent. Family planning clinics ensure confidentiality.</td>
</tr>
<tr>
<td>4. Condoms are not very effective in preventing pregnancy and STIDs.</td>
<td>Fiction: When used consistently and correctly, latex condoms are highly effective in preventing the sexual transmission of HIV and other STIs and are 98% effective in preventing pregnancy.</td>
</tr>
<tr>
<td>5. Normal adolescents do not masturbate once they become sexually active.</td>
<td>Fiction: Masturbation (stimulating one’s genitals) is a normal sexual behavior to achieve sexual pleasure and release. Masturbation is a safe way to express one’s sexuality without the risk of pregnancy or STIs.</td>
</tr>
<tr>
<td>6. Women can get pregnant if a man does not ejaculate inside her vagina.</td>
<td>Fact: If a man ejaculates near the opening of a women’s vagina or touches her vulva while he has semen on his fingers, it is possible for sperm to fertilize an ovum.</td>
</tr>
<tr>
<td>7. Having a sexual experience with someone of the same sex means you are gay or lesbian.</td>
<td>Fiction: Having a same-sex experience does not mean a person is gay or lesbian. 50% of men and 25% of women report having same-sex experiences. Many same-sex experiences occur as a way to explore one’s sexuality. Feelings and attractions, not sexual behavior,</td>
</tr>
</tbody>
</table>
8. A woman will always bleed and feel pain when she has vaginal intercourse for the first time.  

| Fiction: Most women have a hymen, which covers the vaginal entrance. Hymens are torn or stretched during normal physical activity. A small amount of bleeding may occur if a woman’s hymen has never been stretched or torn. Although some women do not experience pain, pain can occur if a woman is not being aroused, which can cause a lack of lubrication, leading to tearing. Pain can also occur if a partner is too rough. |

9. Pulling out is not an effective way to avoid pregnancy?  

| Fact: Pulling out is not a safe method to prevent pregnancy as many men are not able to withdraw the penis on time and pre-ejaculatory fluid can contain sperm from previous ejaculations. |

10. You can’t get STIs from oral sex.  

| Fiction: Unprotected oral sex can put you at risk for HPV, gonorrhea, syphilis, herpes, and hepatitis B. |

11. You would know if you or your partner had an STI.  

| Fiction: Many people who have an STI never have symptoms and can pass them to other partners even if they feel fine. |

**Note:** It is recommended that the leader add more questions that they feel would be important, more up to date and culturally relevant.

**Resources:**
The Fact or Fiction game was adapted from:  
www.advocatesforyouth.org/publications/1206-lessons and  
Session #2: Societal and Cultural Pressures

Purpose:

1. For participants to be aware of how damaging stereotypes are, specifically towards women.

2. For participants to learn about different cultural perspectives and to find a balance between honoring one’s own culture and one’s beliefs.

Materials:

Paper, and pens for sentence completion exercise and safe box questions. Box for safe box. Poster board and markers for the stereotypes of women activity.

Activities:                                                   Time:

1. Answer safe box questions.                                  5 minutes

2. The leader will use deconstructive listening and questions to discuss societal and cultural pressures about how women “should” behave. Leader will facilitate activity by writing down on a poster-board all the behaviors of how a woman “should” behave as well as negative and positive stereotypes regarding women that the participants tell the leader to write. For example, some negative stereotypes are that women are supposed to cook and do the housework, women are not meant to speak out, women are responsible for raising children, etc.
Some examples of positive stereotypes are women are creative, beautiful, strong, etc. Process questions: how do you think a woman “should” behave? Who puts these stereotypes on women and why? What are some negative stereotypes women have?

3. Facilitate discussion in regards to the stereotypes women receive and what “slut shaming” is. See handout E to facilitate discussion on slut shaming.

Process questions: Why do you think women are slut shamed? Have you or a friend ever been slut shamed? If so, how did being slut shamed feel? How can you stop slut shaming?

4. Identify each participant’s dominant cultural discourses as well as local and alternative discourses regarding what sex means to them and their family/culture by doing a sentence completion exercise. Ex: Many of my feelings about sex come from______. My culture/family view sex as______. Process questions: What are your family/friends/society/your beliefs about having sex? Are your beliefs similar or different than your friends or family’s?

5. Wrap up and introduce next weeks topic of sexual orientation.

    a. Leader will process how the second session was for the participants by asking questions such as: what was this
session like for you? Did you learn anything new today?
If so, what did you learn?
b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.
c. Have a closing ritual where the participants will say something that they appreciate about being a woman.
Slut Shaming

**Slut definition:** Slut is a derogatory term with many different meanings. A slut can be a person who is sexually promiscuous, an immoral woman, or a prostitute.

**Slut shaming definition:** Slut shaming is based on sexual double standards that occurs when both men and women degrade or mock a woman because she engages in any form of sexual activity, enjoys having sex, has sex a lot, may even just be rumored to participate in sexual activity, or wears “revealing” or “sexy” clothes. Slut shaming also occurs when other people are jealous of them or simply dislike them.

**Group discussion:** Leader can first ask if the participants know what slut shaming is. Then leader can give definition.

**Terms associated with slut shaming:** Slut, whore, bitch, skank, ho, cunt, trashy, tramp, hooker, easy, etc.

**Group discussion:** Leader can have participants name any other labels they have heard when slut shaming occurs.

**The message of slut shaming:** Sex is bad and people will not like you if you have sex.

**Consequences of slut shaming:** Slut shaming takes away women's rights to express themselves sexually without fear of being scrutinized by men and other women and it objectifies other women's bodies.

**Group discussion:** Leader can ask if participants or anyone they know have ever been
slut shamed? Leader can ask how it felt to be slut shamed or how they reacted to seeing someone being slut shamed? Leader can also ask if participants have slut shamed someone? Ask why they did it and how they felt afterwards?

**Truth about sexual activity:** If you give consent to having sex, if you are using protection, and if you feel safe and comfortable with your partner then there is nothing wrong with you having sex. It is no one’s business and it is ultimately your body, your decision, and your life.

**How to stop slut shaming:**

1. Be aware of the slut shaming thoughts that pop into your mind. The first step is to monitor our thoughts and beliefs so that we can begin questioning them.

2. Ask yourself how does someone else’s sex life affect you and why are you upset by it?

3. Be specific about what is really upsetting you. For example, is a woman was rude to you do not call her a slut as her negative trait has nothing to do with her sexuality.

4. Use social media for good and speak up if you see someone being slut shamed.

5. Start a conversation with your friends when you overhear them engaging in slut shaming. This can be scary but if you approach them calmly wanting to have an open discussion with them you can avoid a fight and educate them.

**Group discussion:** Leader can ask participants how they think they can stop slut shaming.
**Resources:**


http://dictionary.reference.com/browse/slut

http://www.theeighty8.com/5-ways-you-can-stop-slut-shaming-today/

Session #3: Sexual Orientation

Purpose:

1. To give an introduction and define the acronym LGBTQI.
2. To educate participants on sexual orientations, identity, and preferences.
3. To promote acceptance and respect for all people.

Materials:

Computer to show the genderbread girl link and LGBTQI terminology handout. Box, pen and paper for safe box questions.

Activities:

1. Answer safe box questions. 5 minutes
2. Discuss the different sexual preferences that people may have as well as all the different aspects of sexuality by showing them the genderbread girl. Link to the genderbread girl: http://itspronouncedmetrosexual.com/2012/03/the-genderbread-person-v2-0/. Discussion question: did you learn anything about yourself with the genderbread handout? 25 minutes
3. Pass out a handout with all the terms that are used in the LGBTQI community and go over most important terms. 10 minutes

See handout F. Discussion question: Who knows what
LGBTQI stands for? Where there terms that you were unaware of?

4. Have a guest speaker who is a part of the LGBTQI community come in to share their experience. Can substitute a YouTube video if cannot find a speaker.

Group discussion: Allow time for questions for the LGBTQI speaker. Discuss misconceptions they may have had about the LGBTQI community.

5. Wrap up and introduce next weeks topic of self-esteem.

   a. Leader will process how the third session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn?

   b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.

   c. Have a closing ritual where the participants will say something that they appreciated learning about today and
how they will use this new found knowledge outside of the group and educate/inform others.
LGBTQI Terminology

**Agendered** – Person is internally ungendered.

**Ally** – Someone who confronts heterosexism, homophobia, biphobia, transphobia, heterosexual and genderstraight privilege in themselves and others; a concern for the well-being of lesbian, gay, bisexual, trans, and intersex people; and a belief that heterosexism, homophobia, biphobia and transphobia are social justice issues.

**Androgyne** – Person appearing and/or identifying as neither man nor woman, presenting a gender either mixed or neutral.

**Asexual** – Person who is not sexually attracted to anyone or does not have a sexual orientation.

**BDSM:** (Bondage, Discipline/Domination, Submission/Sadism, and Masochism) The terms ‘submission/sadism’ and ‘masochism’ refer to deriving pleasure from inflicting or receiving pain, often in a sexual context. The terms ‘bondage’ and ‘domination’ refer to playing with various power roles, in both sexual and social context. These practices are often misunderstood as abusive, but when practiced in a safe, sane, and consensual manner can be a part of healthy sex life. (Sometimes referred to as ‘leather.’)

**Bear:** The most common definition of a ‘bear’ is a man who has facial/body hair, and a cuddly body. However, the word ‘bear’ means many things to different people, even within the bear movement. Many men who do not have one or all of these characteristics define themselves as bears, making the term a very loose one. ‘Bear’ is often defined as more of an attitude and a sense of comfort with natural masculinity and bodies.

**Berdache** - A generic term used to refer to a third gender person (woman-living- man). The term ‘berdache’ is generally rejected as inappropriate and offensive by Native Peoples because it is a term that was assigned by European settlers to differently gendered Native Peoples. Appropriate terms vary by tribe and include: ‘one-spirit’, ‘two-spirit’, and ‘wintke.’

**Bicurious** – A curiosity about having sexual relations with a same gender/sex person.

**Bigendered** - A person whose gender identity is a combination of male/man and female/woman.

**Biphobia** - The fear of, discrimination against, or hatred of bisexuals, which is often times related to the current binary standard. Biphobia can be seen within the LGBTQI
community, as well as in general society.

**Bisexual** – A person emotionally, physically, and/or sexually attracted to males/men and females/women. This attraction does not have to be equally split between genders and there may be a preference for one gender over others.

**Bottom** - A person who is said to take a more submissive role during sexual interactions. Sometimes referred to as ‘pasivo’ in Latin American cultures. Also known as ‘Catcher,’ this term can be offensive.

**Bottom Surgery** – Surgery on the genitals designed to create a body in harmony with a person’s preferred gender expression.

**Butch** – A person who identifies themselves as masculine, whether it be physically, mentally or emotionally. ‘Butch’ is sometimes used as a derogatory term for lesbians, but it can also be claimed as an affirmative identity label.

**Cisgender** – describes someone who feels comfortable with the gender identity and gender expression expectations assigned to them based on their physical sex.

**Coming Out** – May refer to the process by which one accepts one’s own sexuality, gender identity, or status as an intersexed person (to “come out” to oneself). May also refer to the process by which one shares one’s sexuality, gender identity, or intersexed status with others (to “come out” to friends, etc.). This can be a continual, life-long process for homosexual, bisexual, transgendered, and intersexed individuals.

**Cross-dresser** – Someone who wears clothes of another gender/sex.

**Discrimination** – Prejudice + power. It occurs when members of a more powerful social group behave unjustly or cruelly to members of a less powerful social group. Discrimination can take many forms, including both individual acts of hatred or injustice and institutional denials of privileges normally accorded to other groups. Ongoing discrimination creates a climate of oppression for the affected group.

**Down Low** - See ‘In the Closet.’ Also referred to as ‘D/L.’

**Drag** - The performance of one or multiple genders theatrically.

**Drag King** – A person who performs masculinity theatrically.

**Drag Queen** – A person who performs femininity theatrically.
Dyke – Derogatory term referring to a masculine lesbian. Sometimes adopted affirmatively by lesbians (not necessarily masculine ones) to refer to themselves.

FTM / F2M - Abbreviation for female-to-male transgender or transsexual person.

Gay – 1. Term used in some cultural settings to represent males who are attracted to males in a romantic, erotic and/or emotional sense. Not all men who engage in “homosexual behavior” identify as gay, and as such this label should be used with caution. 2. Term used to refer to the LGBTQI community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

Gender Binary – The idea that there are only two genders – male/female or man/woman and that a person must be strictly gendered as either/or.

Gender Confirming Surgery – Medical surgeries used to modify one’s body to be more congruent with one’s gender identity. See “Sex Reassignment Surgery.”

Gender Cues – What human beings use to attempt to tell the gender/sex of another person. Examples include hairstyle, gait, vocal inflection, body shape, facial hair, etc. Cues vary by culture.

Gender Identity – A person’s sense of being masculine, feminine, or other gendered.

Gender Normative – A person who by nature or by choice conforms to gender based expectations of society. (Also referred to as ‘Genderstraight’.)

Gender Oppression - The societal, institutional, and individual beliefs and practices that privilege cisgender (gender-typical people) and subordinate and disparage transgender or gender variant people. Also known as “genderism.”

Gender Variant – A person who either by nature or by choice does not conform to gender-based expectations of society (e.g. transgender, transsexual, intersex, genderqueer, cross-dresser, etc.).

Genderqueer – A gender variant person whose gender identity is neither male nor female, is between or beyond genders, or is some combination of genders. Often includes a political agenda to challenge gender stereotypes and the gender binary system.

Hermaphrodite—An out-of-date and offensive term for an intersexed person.

(See ‘Intersexed Person’.)

Heteronormativity—The assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to homosexuality and bisexuality.
**Heterosexism** – Prejudice against individuals and groups who display non-heterosexual behaviors or identities, combined with the majority power to impose such prejudice. Usually used to the advantage of the group in power. Any attitude, action, or practice – backed by institutional power – that subordinates people because of their sexual orientation.

**Heterosexual Privilege** – Those benefits derived automatically by being heterosexual that are denied to homosexuals and bisexuals. Also, the benefits homosexuals and bisexuals receive as a result of claiming heterosexual identity or denying homosexual or bisexual identity.

**HIV-phobia** – The irrational fear or hatred of persons living with HIV/AIDS.

**Homophobia** – The irrational fear or hatred of homosexuals, homosexuality, or any behavior or belief that does not conform to rigid sex role stereotypes. It is this fear that enforces sexism as well as heterosexism.

**Homosexual** – A person primarily emotionally, physically, and/or sexually attracted to members of the same sex.

**In the Closet** – Refers to a homosexual, bisexual, transperson or intersex person who will not or cannot disclose their sex, sexuality, sexual orientation or gender identity to their friends, family, co-workers, or society. An intersex person may be closeted due to ignorance about their status since standard medical practice is to “correct,” whenever possible, intersex conditions early in childhood and to hide the medical history from the patient. There are varying degrees of being “in the closet”; for example, a person can be out in their social life, but in the closet at work, or with their family. Also known as ‘Downlow’ or ‘D/L.’

**Intergender** – A person whose gender identity is between genders or a combination of genders.

**Institutional Oppression** – Arrangements of a society used to benefit one group at the expense of another through the use of language, media, education, religion, economics, etc.

**Internalized Oppression** – The process by which a member of an oppressed group comes to accept and live out the inaccurate stereotypes applied to the oppressed group.

**Intersexed Person**—Someone whose sex a doctor has a difficult time categorizing as either male or female. A person whose combination of chromosomes, gonads, hormones, internal sex organs, gonads, and/or genitals differs from one of the two expected patterns.

**Lesbian** – Term used to describe female-identified people attracted romantically,
erotically, and/or emotionally to other female-identified people. The term lesbian is derived from the name of the Greek island of Lesbos and as such is sometimes considered a Eurocentric category that does not necessarily represent the identities of African-Americans and other non-European ethnic groups. This being said, individual female-identified people from diverse ethnic groups, including African-Americans, embrace the term ‘lesbian’ as an identity label.

**LGBTQI** – A common abbreviation for lesbian, gay, bisexual, transgender, queer and intersexed community.

**Lipstick Lesbian** – Usually refers to a lesbian with a feminine gender expression. Can be used in a positive or a derogatory way, depending on who is using it. Is sometimes also used to refer to a lesbian who is seen as automatically passing for heterosexual.

**Male Lesbian**—A male-bodied person who identifies as a lesbian. This differs from a heterosexual male in that a male lesbian is primarily attracted to other lesbian, bisexual or queer identified people. May sometimes identify as gender variant, or as a female/woman. (See ‘Lesbian.’)

**Metrosexual** - First used in 1994 by British journalist Mark Simpson, who coined the term to refer to an urban, heterosexual male with a strong aesthetic sense who spends a great deal of time and money on his appearance and lifestyle. This term can be perceived as derogatory because it reinforces stereotypes that all gay men are fashion-conscious and materialistic.

**MTF / M2F** – Abbreviation for male-to-female transgender or transsexual person.

**Outing** – Involuntary disclosure of one’s sexual orientation, gender identity, or intersex status.

**Pangendered** – A person whose gender identity is comprised of all or many gender expressions.

**Pansexual** – A person who is sexually attracted to all or many gender expressions.

**Passing** – Describes a person's ability to be accepted as their preferred gender/sex or race/ethnic identity or to be seen as heterosexual.

**Polyamory** – Refers to having honest, usually non-possessive, relationships with multiple partners and can include: open relationships, polyfidelity (which involves multiple romantic relationships with sexual contact restricted to those), and sub-relationships (which denote distinguishing between a ‘primary” relationship or
relationships and various "secondary" relationships).

**Prejudice** – A conscious or unconscious negative belief about a whole group of people and its individual members.

**Queer** – 1. An umbrella term which embraces a matrix of sexual preferences, orientations, and habits of the not-exclusively- heterosexual-and-monogamous majority. Queer includes lesbians, gay men, bisexuals, transpeople, intersex persons, the radical sex communities, and many other sexually transgressive (underworld) explorers. 2. This term is sometimes used as a sexual orientation label instead of ‘bisexual’ as a way of acknowledging that there are more than two genders to be attracted to, or as a way of stating a non-heterosexual orientation without having to state who they are attracted to. 3. A reclaimed word that was formerly used solely as a slur but that has been semantically overturned by members of the maligned group, who use it as a term of defiant pride. ‘Queer’ is an example of a word undergoing this process. For decades ‘queer’ was used solely as a derogatory adjective for gays and lesbians, but in the 1980s the term began to be used by gay and lesbian activists as a term of self-identification. Eventually, it came to be used as an umbrella term that included gay men, lesbians, bisexuals, and transgendered people. Nevertheless, a sizable percentage of people to whom this term might apply still hold ‘queer’ to be a hateful insult, and its use by heterosexuals is often considered offensive. Similarly, other reclaimed words are usually offensive to the in-group when used by outsiders, so extreme caution must be taken concerning their use when one is not a member of the group.

**Same Gender Loving** – A term sometimes used by members of the African- American / Black community to express an alternative sexual orientation without relying on terms and symbols of European descent. The term emerged in the early 1990's with the intention of offering Black women who love women and Black men who love men a voice, a way of identifying and being that resonated with the uniqueness of Black culture in life. (Sometimes abbreviated as ‘SGL’.)

**Sex** - A medical term designating a certain combination of gonads, chromosomes, external gender organs, secondary sex characteristics and hormonal balances. Because usually subdivided into ‘male’ and ‘female’, this category does not recognize the existence of intersexed bodies.

**Sex Identity** – How a person identifies physically: female, male, in between, beyond, or neither.

**Sexual Orientation** – The desire for intimate emotional and/or sexual relationships with people of the same gender/sex, another gender/sex, or multiple genders/sexes.
Sexual Reassignment Surgery (SRS) – A term used by some medical professionals to refer to a group of surgical options that alter a person’s “sex”. In most states, one or multiple surgeries are required to achieve legal recognition of gender variance. Also known as “Gender Confirming Surgery.”

Sexuality – A person’s exploration of sexual acts, sexual orientation, sexual pleasure, and desire.

Stealth – This term refers to when a person chooses to be secretive in the public sphere about their gender history, either after transitioning or while successful passing. (Also referred to as ‘going stealth’ or ‘living in stealth mode’.)

Stereotype – A preconceived or oversimplified generalization about an entire group of people without regard for their individual differences. Though often negative, can also be complimentary. Even positive stereotypes can have a negative impact, however, simply because they involve broad generalizations that ignore individual realities.

Straight – Another term for heterosexual.

Straight-Acting – A term usually applied to gay men who readily pass as heterosexual. The term implies that there is a certain way that gay men should act that is significantly different from heterosexual men. Straight-acting gay men are often looked down upon in the LGBTQ community for seemingly accessing heterosexual privilege.

Switch – A person who is both a ‘Top’ and a ‘Bottom’, there may or may not be a preference for one or the other.

Top — A person who is said to take a more dominant role during sexual interactions. May also be known as ‘Pitcher,’ this term can be offensive.

Top Surgery - This term usually refers to surgery for the construction of a male-type chest, but may also refer to breast augmentation.

Trans - An abbreviation that is sometimes used to refer to a gender variant person. This use allows a person to state a gender variant identity without having to disclose hormonal or surgical status/intentions. This term is sometimes used to refer to the gender variant community as a whole.

Transactivism- The political and social movement to create equality for gender variant persons.

Transgender – A person who lives as a member of a gender other than that expected based on anatomical sex. Sexual orientation varies and is not dependent on gender identity.
Transgendered (Trans) Community – A loose category of people who transcend gender norms in a wide variety of ways. The central ethic of this community is unconditional acceptance of individual exercise of freedoms including gender and sexual identity and orientation.

Transhate – The irrational hatred of those who are gender variant, usually expressed through violent and often deadly means.

Tranny Chaser - A term primarily used to describe people who prefer or actively seek transpeople for sexual or romantic relations. While this term is claimed in an affirmative manner by some, it is largely regarded as derogatory.

Transition – This term is primarily used to refer to the process a gender variant person undergoes when changing their bodily appearance either to be more congruent with the gender/sex they feel themselves to be and/or to be in harmony with their preferred gender expression.

Transman—An identity label sometimes adopted by female-to-male transsexuals to signify that they are men while still affirming their history as females. Also referred to as ‘transguy(s).’

Transphobia – The irrational fear of those who are gender variant and/or the inability to deal with gender ambiguity.

Transsexual – A person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.

Transvestite – Someone who dresses in clothing generally identified with the opposite gender/sex. While the terms ‘homosexual’ and ‘transvestite’ have been used synonymously, they are in fact signify two different groups. The majority of transvestites are heterosexual males who derive pleasure from dressing in “women’s clothing”. (The preferred term is ‘cross-dresser,’ but the term ‘transvestite’ is still used in a positive sense in England.)

Transwoman-- An identity label sometimes adopted by male-to-female transsexuals to signify that they are women while still affirming their history as males.

Two-Spirited – Native persons who have attributes of both genders, have distinct gender and social roles in their tribes, and are often involved with mystical rituals (shamans). Their dress is usually mixture of male and female articles and they are seen as a separate or third gender. The term ‘two-spirit’ is usually considered to specific to the Zuni tribe. Similar identity labels vary by tribe and include ‘one-spirit’ and ‘wintke’.
Ze / Hir – Alternate pronouns that are gender neutral and preferred by some gender variant persons. Pronounced /zee/ and /here,/ they replace “he”/”she” and “his”/”hers” respectively.

Examples of how to use these pronouns:

She went to her bedroom. He went to his bedroom. Ze went to hir bedroom.

E went to eir bedroom.

I am her sister. I am his sister. I am hir sister

I am eir sister.

She shaves herself. He shaves himself. Ze shaves hirself.

E shaves emself.

Note: This terminology sheet was created by Eli R. Green and Eric N. Peterson at the LGBT Resource Center at UC Riverside ∙ 2003-2004.

Resource:

Session #4: Self-Esteem

Purpose:

1. To gain awareness of how self-esteem can work for or against the participants and how it affects every aspect of their lives.

2. To help identify positive traits.

3. To develop a support system and bond between participants.

Materials:

Construction paper, pens, markers, crayons, colored pencils, glitter, stickers, magazines, glue, scissors for collages. Dvd player/computer to show the Colbie Caillat video. Box, paper, and pens for the safe box.

Activities:  

Time:

Answer safe box questions 5 minutes

2. Show the music video Try by Colbie Caillat to facilitate discussion regarding self-esteem. YouTube link: https://youtu.be/GXoZLPSw8U8. Group discussion: What message did you receive from the music video? How did the video make you feel? Did you think the women were still beautiful without makeup? Why or why not?
3. Have participants make two collages from magazines, one about how they see themselves now and another how they want to see themselves. Have the participants present their collages.

4. Have each participant write positive traits for each group member on the back of the “present self” collage. Group discussion: How was it like for you to read all the positive traits about yourself? How can you continue to increase your self-esteem?

5. Discuss how self-esteem ties into one’s sexuality. How do you think your self-esteem affects your life? See handout G.

6. Wrap up and introduce next week’s topic of Sexual Anatomy and Sexual Activities.

   a. Leader will process how the fourth session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn?

   b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The
leader would then take home the box, read the question(s) and come prepared with answers for the following week.

c. Have a closing ritual where the participants will say two things that they appreciate about themselves i.e. a personal physical positive characteristic and a positive personality trait.
Handout G

How Self-Esteem Ties Into One’s Sexuality

**Group Leader:** “Westernized cultures, through the use of advertisement, instills in adolescent females that they are to look a particular way in order to be considered beautiful. Therefore, adolescent girls suffer at high rates of emotional problems, low self-image, higher rates of depression, anxiety, and disordered eating than their peers. In addition, dating often drives many adolescents to become preoccupied with their bodily appearance and to experiment with different looks. As a result of focusing on their body image, girls may start to diet or develop eating disorders in the hopes of achieving a “perfect” body.

Self-esteem can effect our sexuality in different ways. One way is if a adolescent girl has low self-esteem she may not want to engage in sexual activity as she may not want her sexual partner to see her naked body. On the other hand someone with low-esteem may go in the opposite direction by engaging in sexual activities, with possibly multiple partners, in the hopes of seeking outside validation to increase their self-esteem.”

**Resources:**


https://www.plannedparenthood.org/learn/body-image
Session #5: Sexual Anatomy and Sexual Activities

Purpose:

1. Educate participants in what different sexual body parts look like and how they function.
2. Educate participants regarding intercourse and other types of sexual activities.

Materials:

Box, paper, and pens for safe box. Paper, pens, crayons, markers for mountain art activity.

Activities:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Answer safe box questions.</td>
<td>5 minutes</td>
</tr>
<tr>
<td>2. Educate participants on the functions of sexual body parts. See handout H. Bring pictures to show sexual body parts. Can use pictures from google or a textbook.</td>
<td>20 minutes</td>
</tr>
<tr>
<td>3. Mountain art activity. See handout I.</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4. Discuss intercourse as well as different types of sexual activities with a partner. When discussing sexual activities have participants name any nicknames for sexual activity to encourage participation and to help participants loosen up regarding this often embarrassing</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
topic. See handout J.

5. Wrap up and introduce next week's topic of masturbation. 

   a. Leader will process how the fifth session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn?

   b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.

   c. Have a closing ritual where the participants will say one thing that they appreciate about their body.
Handout H

Sexual Body Parts

Female Sexual Anatomy and Physiology

External Sex Organs

Vulva- makes up the external genitalia of the female.

Mons veneris/mons pubis- mound of fatty tissue over the female pubic bone. Serves as a protective cushion for the genitals, especially during intercourse.

Labia majoria- two longitudinal folds of skin extending downward and backward from the mons pubis. During sexual excitement it fills with blood and swells.

Labia Minora- two small folds of mucous membrane lying within the labia majora of the female. Protects the vagina and urethra. During sexual arousal the labia minora will darken.

Prepuse- a loose fold of skin that covers the clitoris.

Clitoris- an erectile organ located under the prepuce. Has many nerve endings and is sensitive. Its sole function is to bring sexual pleasure. Most women do not enjoy direct stimulation of the clitoris and prefer stimulation through the prepuce.

Vestibule- entire region between the labia minora, including the urethra and introitus.

Urethral meatus- opening to the urethra.

Introitus and hymen- the introitus is the entrance to the vagina. The hymen is a
thin fold of mucous membrane at the vaginal opening. The hymen varies in thickness and is sometimes absent. During first intercourse if the hymen is still intact there will usually be some tearing, which can be accompanied by a small amount of blood and mild discomfort. Many activities other than intercourse can shred the hymen including vigorous exercise, horseback/bike riding, masturbation, or insertion of tampons.

**Bartholin's glands** - a pair of glands on either side of the vaginal opening that open by a duct into the space between the hymen and the labia minora.

**Perineum** - the tissue between the vagina and the anus.

**Internal Sex Organs**

**Vagina** - a thin-walled muscular tube that leads from the uterus to the vestibule and is used for sexual intercourse, a passageway for menstrual fluid, sperm, and a newborn baby.

**Grafenberg spot** - a structure that is said to lie on the front wall of the vagina and is reputed to bring sexual pleasure when stimulated. The stimulation can result in powerful orgasms accompanied by an expulsion of fluid (female ejaculation).

**Uterus** - the hollow muscular organ that is the site of menstruation, implantation of the fertilizes ovum, and labor; also referred to as the womb.

**Cervix** - doughnut-shaped bottom part of the uterus that protrudes into the top of the vagina.
**Fallopian tubes/Oviducts**- two ducts that transport ova from the ovary to the uterus.

**Ovaries**- the ovary contains oocytes/ova/eggs which during ovulation the ovum travels down to the fallopian tube. The ovaries are the most important producer of female sex hormones (estrogen).

**Other Sex Organs**

**Breasts/Mammary Glands**- sweat glands that produce milk to nourish a newborn child. Breasts are also seen as an erogenous zone and can be stimulated during sexual arousal. Each breast contains a nipple, which a pigmented, wrinkled protuberance on the surface of the breast that contains ducts for the release of milk. Around the nipple is a pigmented ring known as the areola. Some women experience orgasm from breast and nipple stimulation. Breasts are all different in size, shape, and shades of color.

**Male Sexual Anatomy and Physiology**

**External Sex Organs**

**Penis**- male organ urinate and move spermatozoa out of the urethra through ejaculation. The penis has the ability to engorge with blood and stiffen. The penis is composed of three cylinders, two lateral corpora cavernosa that lie on the under sides of the penis and the central spongiosum that lies on the bottom and contains the urethra. containing erectile tissue-spongelike tissue. It is the major organ of the
male sexual pleasure.

**Glans penis**- the flaring, enlarged region at the end of the penis. It is made up of the corona, frenulum, and the meatus. The is the ridge of the glans penis. The frenulum is the fold of skin on the underside of the penis. The meatus is the urethral opening. In many cultures the foreskin is removed through a procedure called a circumcision.

**The root**- the root enters the body below the pubic bone and is attached to internal pelvic muscles.

**Erection**- an erection can occur with any form of stimulation. This excitement causes nerve fibers to swell the arteries of the penis. The erectile tissues fill with blood and the penis stiffens and becomes erect.

**Scrotum**- the scrotum is an external pouch of skin that contains the testicles.

**Internal Sex Organs**

**Testicles**- are egg-shaped glands that rest in the scrotum, each are about two inches long and one inch in diameter. The left testicle often hangs lower. The two main functions are spermatogenesis, the production of sperm, and testosterone production.

**Epididymis**- a comma-shaped organ that sits atop the testicle and holds sperm during maturation.

**Vas Deferens**- one of the two long tubes that convey the sperm from the testes and
in which other fluids are mixed to create semen.

**Seminal Vesicles**- the pair of pouchlike structures lying next to the urinary bladder that secrete a component of semen into the ejaculatory ducts.

**Prostate Gland**- a donut-shaped gland that wraps around the urethra as it comes out of the bladder, contributing fluid to the semen.

**Cowper's Gland/Bulbourethral Gland**- one of a pair of glands located under the prostate gland on either side of the urethra that secretes a fluid into the urethra.

**Resource:**

Handout I

Mountain Art Activity

**Purpose:** This activity allows the participants to use art to express themselves in an open and vulnerable way to an embarrassing or uncomfortable topic of sexual activities.

**Instructions:** Leader will tell participants to each draw a mountain. Along the mountain they will write down or draw all the sexual activities they can think up leading up to intercourse, which is the top of the mountain. Once everyone is done the group will discuss what their mountains look like. The leader will discuss how the mountain represents each girl’s sexual path that they should take at their own pace as it is not a race. Each mountain are different heights and each mountain has a different trail to the top. We should not judge other people’s mountains as it is each girl’s journey into their sexuality.

**Resource:**

Sexual Activities

What Is Sexual Activity?

Sexual activity is any voluntary sexual behavior we do.

Common Sexual Activities:

1. Masturbation
2. Kissing- on the mouth, with tongue, on body parts
3. Touching a partner's nipples, breasts, or sex organs (“hand job,” “fingering”)
4. Sex talk- phone sex, cybersex, sexting, “talking dirty” during sex
5. Rubbing bodies together with or without clothes (“dry sex”)
6. Oral sex (“blow job,” “eating out,” “sixty-nine”)
7. Anal intercourse
8. Vaginal intercourse

Resources


Session #6: Masturbation

**Purpose:**

1. Educate participants on what masturbation is.

2. Dispel myths regarding masturbation.

3. Educate participants on the various ways women can masturbate.

4. To foster a positive view on masturbation by explaining how masturbation is natural and normal.

**Materials:**

Paper and pens for masturbation activity. Box, paper and pens for safe box.

**Activities:**

1. Answer safe box questions.  
   **Time:** 5 minutes

2. Have participants write down what they think masturbation is and what they have heard or been told about it. Leader will read aloud the answers, debunk myths, properly define masturbation, and explain the benefits of masturbation. See handout K.  
   **Time:** 30 minutes

3. Educate participants on the different ways people masturbate. See handout K.  
   **Time:** 10 minutes

4. Have participants split off into dyads and have them discuss their feelings regarding the new found knowledge regarding
masturbation. Then come back together as a group and discuss

5. Wrap up and introduce next week’s topic of

STDs/STIs and safe sex.

   a. Leader will process how the sixth session was for the
      participants by asking questions such as: what was this
      session like for you? Did you learn anything new today?
      If so, what did you learn?

   b. Let the participants know that if any questions were
      unanswered or they were too embarrassed to ask them
      they could write it down and put it in the safe box. The
      leader would then take home the box, read the question(s)
      and come prepared with answers for the following week.

   c. Have a closing ritual where the participants will say
      one thing that they appreciate themselves.
Definition of Masturbation:

Erotic stimulation especially of one's own genital organs commonly resulting in orgasm and achieved by manual or other bodily contact exclusive of sexual intercourse, by instrumental manipulation, occasionally by sexual fantasies, or by various combinations of these agencies.

Reasons for Masturbating:

1. Sexual pleasure
2. To learn about or better understand their bodies
3. As a release
4. To substitute for partner sex
5. General sexual dissatisfaction

Feelings regarding masturbation:

1. Shame
2. Sexual Empowerment (powerful, strong, sexy, independent, satisfied)
3. Fear that one is acting selfishly

Interesting Facts about Masturbation:

1. 60-65% of women masturbate
2. Women who masturbate tend to have higher self-esteem
3. Adolescent girls masturbated less frequently than adolescent boys
Ways to Masturbate:

1. Vibrators
2. Sex toys such as dildos
3. Fingers for clitoral stimulation
4. Can penetrate with fingers or toy but many women do not nor do they need to to orgasm
5. Can use lubrication to increase pleasure and protect against irritation
6. To get aroused women sometimes watch porn, read a romance novel or erotica literature, or use their imagination

Benefits of Masturbation:

1. Reduces stress
2. Releases sexual tension and provides sexual pleasure
3. Increases self-esteem and improves body image
4. Helps people learn how they like to be touched and stimulated sexually
5. Increase the ability to have orgasms

Last Comment:

Masturbation should be viewed as a normal, productive and healthy behavior

Resources:


Fahs, B., & Frank, E. (2014). Notes from the back room: Gender, power, and


Session #7: STIs and Safe Sex

Purpose:

1. Provide education about STIs.
2. Educate and promote safe sex practices.

Materials:

Index cards for STI handshake. Box, paper and pen for safe box. Bananas and condoms
for practicing how to put on a condom correctly.

Activities:

1. Answer safe box questions. 5 minutes
2. Educate participants on STIs, how one contracts them, 35 minutes
how one can prevent them, and what can be done if one
contracts an STI. See handout L.
adventuresforyouth.org/for-professionals/lesson-plans-
professionals/1262?task=view 25 minutes
4. Educate participants on safe sex practices. See handout M. 10 minutes
5. Use props such as a banana to have the participants
practice putting on a condom correctly. 10 minutes
6. Wrap up and introduce next week’s topic of
pregnancy and birth control. 5 minutes
a. Leader will process how the seventh session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn?

b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.

c. Have a closing ritual where the participants will say one thing that they appreciate about the group.
Handout L

STI Information

Statistics:

• In the United States 22% of the population have an incurable STI.
• 19 million STI infections are among men and women between the ages of 15 and 24 years old.
• 40% of sexually active women have had an STI.

Facts:

• Sexually Transmitted Infections (STIs) are infections that are transmitted from one person to another through sexual contact. STIs used to be called sexually transmitted diseases (STDs).
• Many adolescent females do not believe they are at risk for contracting STIs even though they are at a higher risk for developing an STI as their cervix is more vulnerable than an adult woman's cervix.
• Overall, women are more susceptible to gonorrhea, chlamydia, and HIV, although the spread of syphilis and genital warts is usually shared equally between the sexes and women are at a greater risk for long-term complications from STIs because the tissue of the vagina is much more fragile than the skin covering the penis.
• STIs are classified into three categories: ectoparasitic infections, bacterial infections, and viral infections.
Ectoparasitic infections:

**Pubic lice**- pubic lice is a parasitic STI that infests the pubic hair and can be transmitted through sexual contact. Pubic lice can be treated with ointment that comes in a shampoo or cream that kills the insects and eggs. In addition, all clothing, bedsheets and towels must be washed in hot water.

**Scabies**- scabies affects the skin as it can cause rashes and itching and is spread during skin-to-skin contact. Scabies are treated with topical creams and all clothing, bedsheets and towels must be washed in hot water.

Bacterial infections:

**Gonorrhea**- known as the clap or drip. Gonorrhea causes a puslike discharge and frequent often painful urination in men, while most women are asymptomatic (without recognizable symptoms). Transmission of gonorrhea occurs when the mucous membranes come into contact with each other; this can occur during sexual intercourse, oral sex, vulva-to-vulva sex, and anal sex. Gonorrhea can be treated with antibiotics.

**Syphilis**- can be transmitted during sexual contact through small tears in the skin and can be transmitted through the placenta during pregnancy (congenital syphilis). There are three stages of infection. In the first stage there are chancrees (one or more small, red-brown sores) that appear on the vulva, penis, vagina, cervix, anus, mouth or lips. In the second stage reddish patches that look like hives appear on the skin, wartlike growths may appear in the area of the infection,
loss of hair may occur, and the lymph glands in the groin, armpit, and neck
enlarge and become tender. In the third stage the infection goes into remission.

Penicillin is used to treat syphilis.

Chlamydia- is the most commonly reported STI in the United States. It is
transmitted during vaginal intercourse, oral or anal sex. Chlamydia can be
asymptomatic although female symptoms include burning during urination, pain
during sexual intercourse, and pain in the lower abdomen. Male symptoms
include discharge from the penis, burning sensation during urination, burning or
itching around the opening of the penis and pain or swelling in the testicles.

Antibiotics are used to treat chlamydia.

Chancroid- are small bumps that rupture and form painful ulcers. Chancroids are
treated with antibiotics.

Trichomoniasis- is a vaginal infection that results in discomfort, discharge, and
inflammation. Treated with metronidazole.

Bacterial vaginosis (BV)- can cause vaginal discharge and odor but is often
asymptomatic. Treated orally or vaginally with metronidazole or clindamycin.

Vulvovaginal candidiasis (yeast infection)- causes burning, itching and a heavy
discharge. This infection is caused by different fungi present in the vagina and
multiplies when the pH balance of the vagina is disturbed due to antibiotics,
regular douching, pregnancy, oral contraceptive use, diabetes or careless wiping
after defecation. Treatment includes an antifungal prescription or over-the-counter drugs.

**Pelvic inflammatory disease (PID)**- which is an infection of the female genital tract caused by Chlamydia trachomatis and Neisseria gonorrhoeae. PID can cause fever, vaginal discharge, infertility, chronic pelvic pain, and ectopic or tubal pregnancies. PID is treated with antibiotics.

**Viral Infections:**

**Herpes**- herpes is caused by herpes simplex virus (HSV). Herpes simplex I (HSV-1) cause cold sores on the face or lips and herpes simplex II (HSV-2) causes genital ulcerations. Herpes simplex I and II can be spread through vaginal intercourse and anal sex. It is possible for people with HSV to reinfect themselves (autoinoculate) by by touching on open lesion and then rubbing another mucosal area. Although there is no cure for herpes, antiviral drugs are used to shorten the duration of outbreaks.

**Human papillomavirus (HPV)**- HPV can cause genital warts and or cervical cancer. HPV can be transmitted through sexual intercourse, oral sex, vulva-to-vulva sex or anal sex. The treatment for HPV are chemical topical solutions, cryotherapy (freezing the warts with liquid nitrogen), electrosurgical interventions (removal of warts using a hot wire loop), or laser surgery.

**Viral hepatitis**- is caused by impaired liver function and is split into three types: hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV). HAV is
transmitted through fecal-oral contact and is spread by food handlers. HAV symptoms include fatigue, abdominal pain, loss of appetite and diarrhea. HAV is treated with vaccines. HBV is spread through high-risk sexual behaviors. HBV is usually asymptomatic but can cause nausea, headaches, and fever. HBV is treated with vaccines. HCV can be spread through sexual behavior as well as illegal intravenous drug use or unscreened blood transfusions. HCV is usually asymptomatic as well. There are currently no vaccines for HCV.

**Human immunodeficiency (HIV)**- is the retrovirus responsible for the development of AIDS and can be transmitted through bodily fluids, including semen, vaginal fluid, breast milk, and blood, during vaginal or anal intercourse, and through intravenous drug use by sharing needles. HIV is a gradual deterioration of the immune system and it never goes away. Some symptoms include significant weight loss, severe diarrhea, night sweats, oral ulcers, fever, blurred vision. HIV is treated by highly active antiretroviral therapy (HAART), which is a combination of three or more HIV drugs.

**Acquired immune deficiency syndrome (AIDS)**- is a condition of increased susceptibility to opportunistic diseases; results from an infection with HIV transmitted through bodily fluids. AIDS destroys the body's immune system. AIDS is treated by highly active antiretroviral therapy (HAART), which is a combination of three or more HIV drugs.

**Resource:**
Handout M

Safe Sex

What is Safe Sex?

• Safe Sex is protecting oneself against STIs, pregnancy, and engaging in a consenting healthy sexual relationships.

How Can I Have Safer Sex?

• Using contraception methods correctly to protect against STIs, pregnancy or sometimes both depending on the type of birth control.

• Getting tested regularly and having your sexual partner get tested as well.

• Avoiding alcohol as it can affect your decision making skills, which can lead to high-risk sex by not using contraception.

• Stating your needs and wants to your sexual partner.

Examples:

1. Letting your partner know where and how you like to be touched.

2. Letting your partner know your limits when it come to taking risks.

3. Saying no to sex when you do not want to have it.

Resources:


https://www.plannedparenthood.org/learn/stds-hiv-safer-sex/safer-sex
Session #8: Pregnancy and Birth Control

**Purpose:**

1. Educate participants about the process of pregnancy including bodily changes.
2. Discuss alternative decisions when women decide not to keep their baby.
3. Educate participants on different forms of birth control.
4. To decrease teenage pregnancy.

**Materials:**

Box, paper and pen for safe box. Fake belly for participants to wear to feel the weight of being pregnant.

**Activities:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Give statistics of teen pregnancy.</td>
<td>10 minutes</td>
</tr>
<tr>
<td>2. Describe the process of pregnancy. See handout N.</td>
<td>15 minutes</td>
</tr>
<tr>
<td>3. Have participants wear a fake belly to feel what it would be like to be pregnant.</td>
<td>20 minutes</td>
</tr>
<tr>
<td>4. Discuss adoption and abortion. See handout O.</td>
<td>15 minutes</td>
</tr>
<tr>
<td>5. Educate participants with the different forms of birth control including the benefits and side effects.</td>
<td>25 minutes</td>
</tr>
<tr>
<td>See handout P.</td>
<td></td>
</tr>
<tr>
<td>6. Wrap up and introduce next week’s topic of healthy relationships and communication skills.</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>
a. Leader will process how the eighth session was for the participants by asking questions such as: what was this session like for you? Did you learn anything new today? If so, what did you learn?
b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.
c. Have a closing ritual where the participants will say one thing that they appreciate about their body.
Handout N

Pregnancy

Facts

• United States of America has the second highest pregnancy rate for women aged 15-19 in the developed countries.

• Teenage contraception rates are higher in deprived areas of the country compared with affluent areas. These areas are characterized by poor levels of education and poor job prospects.

• High pregnancy rates are high due to low expectations, ignorance and mixed messages. Young people have low expectations when they have been disadvantaged in childhood and have poor expectations of education or the job market. The ignorance occurs when young people lack accurate knowledge of contraception, STIs, relationships, and being a parent. Mixed messages occur when young people are surrounded by sexually explicit material yet adults generally do not talk openly about sex and protection, resulting in unprotected sex.

What is Pregnancy?

• Pregnancy is the period from conception to birth.

• One becomes pregnant when the egg is fertilized by a sperm and then implanted in the lining of the uterus where it develops into the placenta and embryo and later into fetus.
Pregnancy usually lasts for 40 weeks and is divided into three trimesters, each lasting roughly three months.

**Changes Throughout Pregnancy**

- Throughout the pregnancy women experience many changes such as morning sickness (nausea and vomiting), sensitivity to odors, food cravings, fatigue, breast tenderness, constipation, heartburn, increased urination, increase in appetite, ankle or leg swelling, hemorrhoids, increases in varicose veins, sleep problems, and increased or decreased sex drive.

- During this time women's hormonal levels are fluctuated thus women go through a range of emotions such as excitement, happiness, and anxiety.

**Complications Throughout Pregnancy**

- The majority of women go through pregnancy without any problems.

- Since pregnancy is a complex process some problems can arise. Some problems include: ectopic pregnancies, spontaneous abortion (miscarriage), chromosomal abnormalities, Rh incompatibility, and toxemia.

- It is important to note that in order to have a healthy pregnancy nutrition and light exercise are recommended.

- Nicotine, alcohol, drugs, and caffeine are strongly recommended to avoid as they can cause physical or mental deficiencies, low birth weight, and spontaneous abortion.
Resources:


Adoption and Abortion

Abortion

Facts

- In 2000, one-third of pregnancies among 15 to 18 year olds was terminated through abortion. Abortion is the procedure that terminates a human pregnancy.
- Abortions can be performed as either first- or second-trimester procedure.

First-trimester and Second-trimester Abortions

- The first-trimester abortion occurs within the first 14 weeks of pregnancy. The procedures that are used are vacuum aspiration, using suction to empty the contents of the uterus.
- The second-trimester abortion occurs between the 14th and 21st weeks of pregnancy. There are multiple procedures that are used during the first and second-trimester. Dilation and evacuation (D&E) is used, which involves cervical dilation and vacuum aspiration of the uterus. Another procedure is induced labor procedure, which uses drugs to start labor. Saline abortion is a procedure in which amniotic fluid is removed and replaced with a saline solution causing premature delivery of the fetus. Hysterotomy is another abortion procedure that surgically removes the fetus through the abdomen. Lastly, there are medical abortions which use medicine (Mifepristone, RU-486, Methotrexate) to end a pregnancy. These procedures involve risks such as uterine perforation,
cervical laceration, severe hemorrhaging, infection, and anesthesia-related complications, which can increase the risk of death.

**Reasons Women Have Abortions**

- They believe that a baby would interfere with their education or career goals.
- The inability to provide financially for a baby
- Difficulties with the father
- Not wanting people to know that they are sexually active
- Pressure from their partner or family
- Fetal deformity
- Risks to the mother's health
- Having several children already
- Rape or incest

This decision is very complex and difficult

**Psychological Effects From Having an Abortion**

- Psychological effects are separated into three categories; positive emotions, socially based emotions, and internally based emotions.
- Positive emotions include relief and happiness.
- Socially based emotions include shame, guilt, and fear of disapproval.
- Internally based emotions include regret, anxiety, depression, doubt, and anger.
- Many women cycle through these reactions.
If the woman's negative psychological effects are severe it is important for them to seek support and help from her friends, family, healthcare provider and therapist.

Why is this a Controversial Issue?

• This is a controversial issue as some people believe that abortion should be illegal. These people are known as pro-life supporters and they believe that human life begins at contraception thus an embryo is a person and an abortion is murder.

• Pro-choice supporters are on the other side of the issue as they believe that personhood does not begin at conception and that the decision to have an abortion should be left up to the women and should not be regulated by the government.

• Abortion is also controversial as in the United States, states determine specific laws concerning mandatory parental notification or parental consent for an abortion for daughters under the age of 18. Many states have mandatory parental consent or reporting laws. The states with mandatory parental notification can make it more difficult for teens wanting an abortion as they may be thrown out of the house or may be unable to get an abortion if the parent prevents them from doing so.

Adoption

What is Adoption?

• Adoption consists of legally giving up parental rights and responsibilities over to
another person or persons. This is usually done through adoption agencies as a traditional closed adoption (no communication between biologic and adoptive parents) and open adoption which consists of four levels: restricted open adoption, semi-opened adoption, full open adoption, or continuing open adoption.

**Forms of Adoption**

**Restricted open adoption**- occurs as arrangements are made for pictures and information about the child's development to be sent periodically to the birthparents for a specified time following placement. Adopters sign an agreement to furnish the material, and the adoption agency serves as the post office.

**Semi-opened adoption**- when the birthparents meet the people who will be adopting the child, but no identifying information is shared.

**Full open adoption**- occurs when both sets of parents meet and share information.

**Continuing open adoption**- occurs when the birth-parents and adoptive parents establish a plan for continuing contact with one another and the child over the course of the child's development. It is assumed that open adoption differs from closed adoption in that, in the former, adoptive parents will at some point share this information with the adoptee.

**Reasons for Choosing Adoption**

- Not feeling prepared to be a parent.
- Lack of familial support.
• Lack of financial support.
• Person may have higher educational aspirations.
• Pressure from the significant people in their life.
• Wanting to provide a better life for their child may play a role in choosing adoption for their baby.

Feelings After Adoption is Completed

• Sadness
• Regret
• Doubt
• Depression
• Relief

Resource:
Contraception (Birth Control)

What is Birth Control?

- The prevention of pregnancy by abstinence, or the use of certain devices or surgical procedures to prevent ovulation, fertilization, or implantation.

Forms of Birth Control

**Barrier methods:** prevent the sperm from entering the uterus.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Effectiveness</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condoms</strong></td>
<td>A latex, animal membrane, or polyurethane sheath that fits over the penis and is used for protection against pregnancy and sexually transmitted infections. Polyurethane female condoms- protect the vaginal walls.</td>
<td>Latex and polyurethane condoms- 85% effective for typical use and 98% effective for perfect use. Female condoms-79% effective for typical use and 95% effective for perfect use.</td>
<td>1. Protect against pregnancy STIs. 2. Condoms are inexpensive and do not require a prescription.</td>
<td>1. People may feel a reduced sensation or feel slightly uncomfortable. 2. Condoms can be too big and slip off. 3. People may be allergic. 4. Condoms can tear if there is not proper lubrication.</td>
</tr>
<tr>
<td><strong>Diaphragm</strong></td>
<td>Consists of a latex dome on a flexible spring rim that fits over the cervix and can be used with spermicidal cream or jelly. After intercourse the diaphragm must be taken out after 6 or 8 hours but never more than 24 hours.</td>
<td>Effectiveness rates: 84% for typical use and 94% for perfect use.</td>
<td>1. It does not affect hormonal levels. 2. Is not very expensive.</td>
<td>1. A physician needs to fit and prescribe the diaphragm. 2. May increase the risk of toxic shock syndrome, urinary tract infection, and postcoital drip. 3. It can develop a bad odor if left in place too long.</td>
</tr>
<tr>
<td><strong>Contraceptive Sponge</strong></td>
<td>A polyurethane sponge</td>
<td>Effectiveness</td>
<td>1. Can be</td>
<td>1. May increase risk of</td>
</tr>
</tbody>
</table>
impregnated with spermicide, which is inserted into the vagina.

rates- 75% for typical use and 89% for perfect use.

purchased without a prescription.
2. Does not affect hormonal levels
3. Once inserted, sexual intercourse can occur multiple times in a 24 hour period.

toxic shock syndrome and urinary tract infections.
2. Can leave a bad odor if left in place too long.
3. Can be expensive if used frequently.
4. Can be difficult to insert and remove.
5. Can be uncomfortable for men as they may feel the sponge.

A plastic or rubber cover for the cervix that provides a contraceptive barrier to sperm.

Effectiveness- 86% for typical use.
1. Can be left into place for 48 hours.
2. Does not affect hormonal levels.

1. Can increase the risk of toxic shock syndrome, urinary tract infections, postcoital drip, and vaginal odors.
2. Needs to be fitted by a healthcare provider.
3. Can cause discomfort during intercourse.

Hormonal Methods- consist of synthetic hormones that change hormonal levels to interrupt the production of ova to prevent fertilization and implantation.

<table>
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</thead>
<tbody>
<tr>
<td>Combination Birth Control Pill</td>
<td>An oral contraception that contains synthetic estrogen and progesterone. Birth control pills work as they thicken the cervical mucus, which inhibits the mobility of sperm) and the hormones prevent the pituitary gland from sending hormones to cause the ovaries to begin maturation of an ovum.</td>
<td>Effectiveness rates- 92% for typical use and 99.7 for perfect use. For the pill to be effective it is extremely important for the pill to be taken every day at the same time of</td>
<td>1. Is extremely effective if taken correctly. 2. Reduces menstrual flow, menstruation cramps, premenstrual syndrome, facial acne, ovarian cysts, and</td>
<td>1. Does not protect against STIs. 2. Can be expensive. 3. Can decrease its effectiveness if used with certain other medications. 4. Should not be taken if a person smokes as it can increase a heart attack.</td>
</tr>
</tbody>
</table>
The pill usually are taken on a “21-day or 28-day regimen and started on the 1st or 5th day of menstruation or on the 1st Sunday after menstruation. In the 28-day pack there are seven placebo pills that are sugar pills, used as reminder pills.

| Hormonal Ring (NuvaRing) | A small plastic contraceptive ring that is inserted into the vagina once a month and releases a constant dose of estrogen and progestin. | Effectiveness rates-99.7% but can be lower when used with other medications. | 1. Has a high effectiveness rate. 2. Reduces the flow of menstruation, menstrual cramps, and premenstrual syndrome. 3. Can provide protection from ovarian and endometrial cancer. | 1. Does not protect against STIs. 2. Can cause weight gain or loss, breast tenderness, nausea, mood changes, changes in sexual desire, and increased vaginal irritation and discharge. |
| Hormonal Patch (Ortho Evra patch) | Thin, peach-colored patch that sticks to the skin and time-releases synthetic estrogen and progestin into the bloodstream to inhibit ovulation, increase cervical mucus, and render the uterus inhospitable. | Effectiveness rate- 99.7% with perfect use. Although the patch can be less effective in women who weight more than 198 pounds. | 1. Has a high effectiveness rate. 2. Reduces menstrual flow, menstrual cramps, and premenstrual syndrome. 3. Protects against ovarian and endometrial cancer and ovarian cysts. | 1. Does not protect against STIs. 2. Can cause weight gain or loss, breast tenderness, nausea, mood changes, changes in sexual desire, and increased vaginal irritation and discharge. |
| Minipills (Progestin-) | Pill that contains only synthetic | Effectiveness-92% for typical | 1. Can be used by women who | 1. More expensive. 2. Slightly less effective |
only pills) progesterone and no estrogen. use and 99.7% for perfect use. smoke or are breastfeeding. 2. Have fewer side effects than combined-hormone pills. than combination pills. 3. Require obsessive regularity in pill-taking. 4. Can cause irregular bleeding.

**Subdermal Contraceptive Implant (Norplant)**

Implant that time-releases a constant dose of progestin to inhibit ovulation. Doses are implanted in a woman's arm and that can remain in place for up to 5 years.

Effectiveness-99.95% for the first year of use and rates decrease after the third year.

1. Are effective, and long-lasting, 2. Contains no estrogen side effects.

1. Insertion costs are expensive. 2. Users may experience irregular bleeding, acne, nausea, headaches, weight gain or loss, and general weakness. 3. May experience scars after the removal of implant, and pain during removal.

**Hormonal Injectables (Depo-Provera)**

Prevents ovulation and thickens cervical mucus.

Effectiveness-97% for typical use and 99.7% for perfect use.

1. Highly effective, as one injection lasts for 3 months. 2. Is moderately expensive. 3. Reduces risk of endometrial and ovarian cancer. 4. Decreases cramping. 5. Users usually have lighter periods and 30-50% of users have no menstrual periods.

1. User must go to the doctors office for the injection every 3 months. 2. Injections can cause irregular bleeding. 3. Other side effects include: fatigue, headaches, appetite increase, increase in cervical, liver and breast cancer, and decrease in bone density.

**Chemical Methods** - work by reducing the survival of sperm in the vagina.
### Method

<table>
<thead>
<tr>
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<th>Effectiveness</th>
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<th>Disadvantage</th>
</tr>
</thead>
</table>
| **Spermicides**         | Works by reducing the survival of sperm in the vagina. Comes in creams,     | Effectiveness rate- 71% for typical    | 1. Easy to use.                                                            | 1. May be expensive depending on frequency of intercourse.  
|                        | gels, foams, suppositories, and films.                                      | users and 82% for perfect use. The     | 2. Does not require a prescription.                                         | 2. May cause allergic reactions, vaginal skin irritations.  
|                        |                                                                           | foam is more effective than jelly,     | 3. Provides lubrication during intercourse.                                 | 3. May increase urinary tract infections.                                     |
|                        |                                                                           | cream, film or suppositories.          | 4. There are no serious side effects.                                       |                                                                              |

**Intrauterine methods** - small plastic devices that are inserted into a woman's uterus.

### Method

<table>
<thead>
<tr>
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<th>Description</th>
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<th>Disadvantage</th>
</tr>
</thead>
</table>
| **Intrauterine Device (IUD)** and **Intrauterine System (IUS)** | Are inserted by a healthcare provider. They create a low-grade infection of the uterus, which may interfere with sperm mobility and block sperm from passing from the Fallopian tubes and joining with an ovum. | Effectiveness rates range from 99.2-99.9%.                                | 1. Are the least expensive method over time.  
|         |                                                                           |                                        | 2. It decreases menstrual flow.                                             | 1. Do not protect against STIs.  
|         |                                                                           |                                        |                                                                             | 2. May cause irregular bleeding, and increase risk of uterine perforation.  
|         |                                                                           |                                        |                                                                             | 3. Users with multiple sexual partners are at an increased risk of pelvic inflammatory disease. |

**Natural Methods** - involves calculating ovulation and avoiding sexual intercourse during ovulation and other unsafe times.

### Method

<table>
<thead>
<tr>
<th>Method</th>
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<th>Effectiveness</th>
<th>Advantages</th>
<th>Disadvantage</th>
</tr>
</thead>
</table>
| **Natural Family** | Involves calculating ovulation | Effectiveness- | 1. Is acceptable | 1. Does not protect against  

Planning (NFP)/Sympto-thermal Method and avoiding intercourse during ovulation by using the rhythm method and fertility awareness method by calculating the basal body temperature. 75% for typical use and 99% for perfect use. Form of birth control for religious reasons. 2. Is inexpensive. 3. Has no side effects. STIs. 2. Has low effectiveness rates. 3. Women who have irregular cycles may have a hard time interpreting their charts.

Withdrawal Occurs when the penis is withdrawn from the vagina during ejaculation. Effectiveness rates- 73% for typical use and 96% for perfect use. 1. Is an acceptable method for religious reasons. 2. It is free. 3. Has no side effects. 1. Does not protect against STIs. 2. Can be stressful for both partners as men might find it difficult to withdraw their penis before ejaculation. 3. Has low effectiveness rates.

Abstinence Not engaging in sexual intercourse. 100% effective 1. Protects against some STIs. 2. Used for religious reasons. 1. May be too difficult to abstain from sexual intercourse for some people.

Permanent (Surgical) Methods- causes permanent infertility through sterilization.

<table>
<thead>
<tr>
<th>Method</th>
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<th>Effectiveness</th>
<th>Advantages</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sterilization</td>
<td>Surgical procedure in which the Fallopian tubes are cut, tied, or cauterized, for permanent contraception.</td>
<td>99-99.9% effective.</td>
<td>1. Highly effective. 2. Has a quick recovery. 3. Has few long-term side effects.</td>
<td>1. Surgery is required. 2. Can be expensive. 3. Provides no protection from STIs. 4. Must be considered irreversible.</td>
</tr>
<tr>
<td>Male Sterilization</td>
<td>Surgical procedure for permanent contraception where the vas deferens are cut, tied, or cauterized.</td>
<td>99-99.9% effective.</td>
<td>1. Highly effective. 2. Has a quick recovery.</td>
<td>1. Surgery is required. 2. Can be expensive. 3. Provides no protection from STIs.</td>
</tr>
</tbody>
</table>
3. Has few long-term side effects.
4. Must be considered irreversible.

Emergency Contraception (EC)- prevents pregnancy after unprotected vaginal intercourse.

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Effectiveness</th>
<th>Advantages</th>
<th>Disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning After Pill/Plan B</td>
<td>A pill that if taken within 72 hours of unprotected intercourse.</td>
<td>Risk of pregnancy is reduced by 75%</td>
<td>1. Does not require a prescription. 2. Is easy to use.</td>
<td>1. Is controversial. 2. Has many side effects that can last for 1-2 days such as nausea, vomiting, cramping, breast tenderness, headaches, and abdominal pain</td>
</tr>
</tbody>
</table>

Resource:
Session #9: Healthy Relationships/Communication Skills

**Purpose:**

1. Educate participants regarding healthy relationships.

2. Foster good communications skills.

**Materials:**

Communication skills handout to pass out to the participants. Box, paper and pens for safe box questions.

**Activities:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Answer safe box questions.</td>
<td>5 minutes</td>
</tr>
<tr>
<td>2. Have participants discuss how communication is in their households and with their friends or partners. Discuss what they like or would want to change about their communication styles.</td>
<td>30 minutes</td>
</tr>
<tr>
<td>3. Educate on fair fighting rules and “I” statements. Pass out communication skills handout. See handout Q.</td>
<td>25 minutes</td>
</tr>
<tr>
<td>4. Have participants role play initiating safe sex talks with their partners including their wants and needs.</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5. Wrap up and discuss what the last session of this group will look like next week.</td>
<td>10 minutes</td>
</tr>
</tbody>
</table>

a. Leader will process how the ninth session was for the
participants by asking questions such as: what was this session like for you? Did you learn anything new today?
If so, what did you learn? How are you feeling about next week being our last session?

b. Let the participants know that if any questions were unanswered or they were too embarrassed to ask them they could write it down and put it in the safe box. The leader would then take home the box, read the question(s) and come prepared with answers for the following week.

c. Have a closing ritual where the participants will say what that they appreciate about their family, friends, and/or partner.
Handout Q

Communication Skills

Fair Fighting Rules

Before you begin, ask yourself why you feel upset.
Are you truly angry because your partner left the mustard on the counter? Or are you upset because you feel like you’re doing an uneven share of the housework, and this is just one more piece of evidence? Take time to think about your own feelings before starting an argument.

Discuss one issue at a time.
“You shouldn’t be spending so much money without talking to me” can quickly turn into “You don’t care about our family”. Now you need to resolve two problems instead of one. Plus, when an argument starts to get off topic, it can easily become about everything a person has ever done wrong. We’ve all done a lot wrong, so this can be especially cumbersome.

No degrading language.
Discuss the issue, not the person. No put-downs, swearing, or name-calling. Degrading language is an attempt to express negative feelings while making sure your partner feels just as bad. This will just lead to more character attacks while the original issue is forgotten.

Express your feelings with words and take responsibility for them.
“I feel angry.” “I feel hurt when you ignore my phone calls.” “I feel scared when you yell.” These are good ways to express how you feel. Starting with “I” is a good technique to help you take responsibility for your feelings (no, you can’t say whatever you want as long as it starts with “I”).

Take turns talking.
This can be tough, but be careful not to interrupt. If this rule is difficult to follow, try setting a timer allowing 1 minute for each person to speak without interruption. Don’t spend your partner’s minute thinking about what you want to say. Listen!

No stonewalling.
Sometimes, the easiest way to respond to an argument is to retreat into your shell and refuse to speak. This refusal to communicate is called stonewalling. You might feel better temporarily, but the original issue will remain unresolved and your partner will feel more upset. If you absolutely cannot go on, tell your partner you need to take a time-out. Agree to resume the discussion later.
No yelling.
Sometimes arguments are “won” by being the loudest, but the problem only gets worse.

Take a time-out if things get too heated.
In a perfect world we would all follow these rules 100% of the time, but it just doesn’t work like that. If an argument starts to become personal or heated, take a time-out. Agree on a time to come back and discuss the problem after everyone has cooled down.

Attempt to come to a compromise or an understanding.
There isn’t always a perfect answer to an argument. Life is just too messy for that. Do your best to come to a compromise (this will mean some give and take from both sides). If you can’t come to a compromise, merely understanding can help soothe negative feelings.

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“I” statements:

“I” Statements: Take responsibility for your feelings by using “I” statements rather than “you” statements. “I” statements are much more likely to be heard as they minimize blame and defensiveness.

How to convert “You” Statements to “I” Statements:

<table>
<thead>
<tr>
<th>“You” Statements</th>
<th>“I” Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You make me furious”</td>
<td>“I’m furious”</td>
</tr>
<tr>
<td>“You're driving me crazy”</td>
<td>“I feel confused and crazy”</td>
</tr>
</tbody>
</table>

Resources:


Session #10: Closing

Purpose:

1. Celebrate all the new found knowledge learned.
2. Reward the dedication it took to finish G.I.R.L.S.
3. Wrap up any unanswered questions.
4. Discuss what the participants learned.

Materials: Box, paper and pens for safe box questions. Graduation certificates.

Activities: Time:

1. Answer safe box questions. 5 minutes
2. Discuss what participants learned and what they will take away from this group. 25 minutes
3. Process feelings about ending the group. 20 minutes
4. Give certificates and have a graduation ceremony to make participants feel empowered. See handout R. 30 minutes
5. Wrap up. 10 minutes
   a. Have a closing ritual where the participants will say what that they appreciate about this group, and about themselves.
CERTIFICATE Of Graduation

awarded to:

for

Graduating from G.I.R.L.S: Getting into Real Life Sexuality

Signature_________________________ Date_________________________