2014

Integration of Sexuality Content into an Occupational Therapy Curriculum

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INTEGRATION OF SEXUALITY CONTENT INTO AN OCCUPATIONAL THERAPY CURRICULUM

By

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master’s of Occupational Therapy

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This Scholarly Project Paper, submitted by Brittany Larson and Sarah Stutz in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisory under whom the work has been done and is hereby approved.

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Title: Integration of Sexuality Content into an Occupational Therapy Curriculum

Department: Occupational Therapy

Degree: Master’s of Occupational Therapy

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ABSTRACT

Sexuality is a broad term that can be used to encompass other terms such as sexual expression and sexual functioning, and can be defined as a holistic concept of the individual that is more than just physical sexual behavior but also relates to thoughts and feelings of everyday life (Couldrick, 1998a). Sexuality and sexual functioning are considered an activity of daily living (ADL) by the Occupational Therapy Practice Framework: Domain and Process (2008); however, it is a topic that is not being routinely addressed with clients by occupational therapists or other healthcare professionals (Hattjar, 2012). Studies show there is a significant lack of information given to clients in regard to sexuality, as well as dissatisfaction with the services that are provided for sexuality. This information implies an increase in knowledge, experience, and comfort levels with sexuality needs to be addressed with occupational therapists and occupational therapy students in order to treat clients in a holistic and client-centered manner.

A comprehensive literature review was completed to identify key aspects of sexuality. The literature review revealed a significant lack in student and practitioner confidence and competence in addressing sexuality in a clinical setting. After an extensive search regarding the topic of sexuality within the profession of occupational therapy it was found that much of the limited literature stems from the late 1980’s to early 1990’s, yet the literature from the 2000’s continue to address the same issues. Due to the reported low levels of comfort for occupational therapy students and practitioners regarding sexuality and the role occupational therapists play in addressing the subject with clients, the following product was developed. There was a dearth of
the information and no evidenced-based articles were located regarding sexuality or how to teach about the topic.

The product created includes lesson plans that address different aspects of physical and/or psychosocial impairments that may impact sexuality. The product lesson plans consist of varying lectures, readings and activities, to be incorporated into several courses throughout the duration of an occupational therapy professional program. The goal of this product is to increase exposure to issues of sexuality and sexual functioning throughout the curricula of a Midwestern professional occupational therapy program in order to create competent and comfortable practitioners within the field.
CHAPTER I
INTRODUCTION

Expressing sexuality is a basic human need, and an integral part of human occupation. Sexuality is a broad term that encompasses other terms, such as sexual expression and sexual functioning, and can be defined as a holistic concept of the individual that is more than just physical sexual behaviors as it relates to thoughts and feelings of everyday life (Couldrick, 1998a). The *Occupational Therapy Practice Framework: Domain and Process* (2008) considers sexuality or sexual functioning as an activity of daily living (ADL), yet it is a topic that is not routinely addressed by occupational therapists or other healthcare professionals (Hattjar, 2012). There are several reasons why sexuality is not consistently addressed by occupational therapists. Some of these reasons include: therapist discomfort with the topic; therapist lack of educational preparedness for addressing sexual activity and sexuality, and not having enough time to address the topic due to productivity demands (Hattjar, 2012).

The primary core skills of occupational therapists suggest that a greater role in sexual habilitation or rehabilitation could be fulfilled (Couldrick, 1998a). However, an extensive search of the literature has shown that many occupational therapy students and practitioners feel uncomfortable and unprepared to discuss sexuality or sexual functioning concerns with clients. Sexuality is an area of occupation that is addressed in many occupational therapy programs around the world, however the degree to which it is
addressed is significantly lower than many other occupations. According to Payne et al. (1988) the inconsistency between educational programs in the U.S. is attributed to the uncertain role of occupational therapists within the profession to teach clients adaptive sexual functioning.

Occupational therapists aim to treat clients holistically by taking in every aspect of the person into consideration. How can occupational therapists and other healthcare providers address the topic of sexuality and sexual activity in a professional manner? To answer this question, several tools have been created over the past several decades to aid in the process. Psychologist Jack Annon (1976) developed the PLISSIT Model as a facilitation tool in order to increase healthcare professionals’ ability and likelihood to address sexuality and sexual activity on a regular basis with clients (Hattjar, 2012). The model, as an aid to memory, provides four levels of approach P-LI-SS-IT, as each letter or pair of letters suggests methods for handling presented sexual concerns of clients (Annon, 1976). A brief list of some other tools to assist in the evaluation and intervention process include: the BETTER Model (Mick et al., 2003), the Kingsberg Brief Assessment (Kingsberg, 2006), the Beck Depression Inventory, 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996), the Multidimensional Sexuality Questionnaire (MSQ; Snell, Fisher & Walters, 1993), and the Trueblood Sexual Attitudes Questionnaire (TSAQ; Trueblood, Hannon & Hall, 1998). Despite the available tools to ease discussion of sexuality with clients it is still reported by students and practitioners that there is a low level of comfort and competency to address the topic. The study conducted by Payne, Green, and Corbin (1988), shows that sexuality or sexual functioning is not addressed in an occupational therapy student’s education to a high degree, which has the potential for
a significant impact on a student’s level of competence and confidence in regards to addressing sexuality with clients. Despite this being an issue brought to light in the late 1980’s, the current literature does not clearly state what has been done since then to address this issue. A pilot study conducted by Farkas and Reynolds (2013) concluded that comfort level, educational background, continuing education and/or access to resources has an impact on whether the therapist will address sexual issues with clients. From the study, 66% of the occupational therapists surveyed reported a lack of comfort, by indicating feeling some or no comfort, with addressing sexual issues with clients. Of those surveyed, 84% of the participants indicated limited or no education and/or literature regarding addressing sexual issues with clients (Farkas & Reynolds, 2012).

According to Esmail, Darry, Walter and Knupp (2010) prior to the 1970’s, minimal research was conducted on sexuality and disability. The topic of sexuality was traditionally considered personal and private, therefore, not a necessary component of rehabilitation. Some authors in the 1980’s began to imply that sexuality was an essential domain of concern for occupational therapists to consider in regard to the psychosocial or physical aspects of therapy when working with adolescents, adults, or elderly people (Couldrick, 1998a). However, after an extensive search of the literature on whether or not sexuality and sexual functioning is being addressed in occupational therapy, it remains unclear from the professional literature or from practice if these topics are universally accepted aspects of the occupational therapy. Even within models of practice and frames of reference, which help to guide occupational therapy practice, there is debate about whether to include sexuality as an occupation.
Despite some research indicating the importance of sexuality, it is often ignored in occupational therapy. According to Sakellariou and Algado (2006) confusion about the connection with occupation and the importance to the individual may be one reason why sexuality is left out of the research. Failure to address sexuality as an integral part of the client could compromise therapy and lead to suboptimal therapeutic encounters and outcomes (Sakellariou & Algado, 2006). Through the research, it is evident there is an increasing recognition of the importance that expression of sexuality plays in the quality of life of individuals.

Based on the findings through the literature review process it was found that OT students and practitioners are not comfortable discussing the subject of sexuality with clients. The product of this scholarly project is a series of lesson plans (learning activities) to be incorporated throughout the curriculum of a Midwestern professional occupational therapy program. The lesson plans include a variety of lectures, readings, and interactive activities to increase exposure, comfort level and competence for students when discussing sexuality and sexual functioning concerns with clients, while on fieldworks and as entering practitioners. This product is designed in accordance with the 2011 standards (“Accreditation Council,” 2011) for an accredited education program for occupational therapy and with the theoretical model used to guide the curriculum design of a Midwestern professional OT program.

The theoretical model utilized for this scholarly project was the Occupational Adaptation Model (OA), which allows each person to master and respond adaptively to the various occupational challenges that are encountered in the course of a lifetime in order to respond to future occupational challenges. A developmental process is presumed
where occupation readiness skills in the person subsystems (sensory, cognitive, and psychosocial) set the stage for interaction in the environmental contexts of work, play, and leisure (Schkade & McClung, 2001; Turpin & Iwama, 2011). According to the Student Manual (2011) the intent of the Midwestern occupational therapy program is to develop students capable of assisting individuals to both assume the roles appropriate to their developmental position and to adapt to the challenges inherently present at each point in the developmental process with the common goal of competence in occupational functioning. With the OA model guiding this product, the goal is to engage students as active learners through engagement in occupational learning activities in regard to addressing sexuality and sexual functioning with clients with regular challenges toward personal, academic and professional growth. Adjustments in the learning activities may be made by the educators in response to the student’s mastery of the subject. The students are encouraged to take responsibility for learning and become the agent of change in relation to acquisition of professional knowledge, and to increase personal comfort level and confidence in addressing sexuality with clients. Through the OA model, students are expected to acquire the tools to not only assist clients with adaptive processes across the lifespan but also to enable client participation in valued occupations, such as the ADL of sexuality. This product is to be incorporated into the existing curriculum design of the Midwestern OT Program, where students are expected to develop the knowledge, skills and adaptive capacity needed to address occupational challenges inherent to the role of an occupational therapist and the reflective skills needed to sustain life-long learning (“Student Manual,” 2011).
Chapter I presented an outline of the literature found regarding the topic of sexuality as it pertains to the profession of occupational therapy when addressing concerns with clients. Chapter II provides a comprehensive review of the literature building on the literature presented in Chapter I. Chapter III is a description of the methodology used to develop the educational lesson plans for a Midwestern professional occupational therapy program curriculum. Chapter IV includes the purpose, description, and the entirety of the finished product. Chapter V culminates with the summary and recommendations for future action.
CHAPTER II
LITERATURE REVIEW

Introduction

Expressing sexuality is a basic human need, and an integral part of human occupation. Sexuality is a broad term that encompasses other terms, such as sexual expression and sexual functioning, and can be defined as a holistic concept of the individual that is more than just physical sexual behaviors as it relates to thoughts and feelings of everyday life (Couldrick, 1998a). The *Occupational Therapy Practice Framework: Domain and Process* (2008) considers sexuality or sexual functioning as an activity of daily living (ADL), yet it is a topic that is not routinely addressed by occupational therapists or other healthcare professionals (Hattjar, 2012). There are several reasons why sexuality is not consistently addressed by occupational therapists. Some of these reasons include: therapist discomfort with the topic; therapist lack of educational preparedness for addressing sexual activity and sexuality, and not having enough time to address the topic due to productivity demands (Hattjar, 2012).

Sexuality Definition

Individuals start and end their life as sexual beings with many experiences, feelings, and emotions in-between. Sexuality is a broad term that can be used to encompass other terms such as sexual expression and sexual functioning and can be
defined as a holistic concept of the individual that is more than just physical sexual behavior but also relates to thoughts and feelings of everyday life (Couldrick, 1998a).

Sexuality also encompasses one’s feelings of femininity or masculinity as well as how an individual acts, dresses, speaks and relates to others in their social and interpersonal relationships (Yallop & Fitzgerald, 1997).

**Role of Occupational Therapy**

The role of occupational therapy is that of assisting patients in achieving an optimal level of independence in regards to meaningful occupations such as sexual activity and other activities of daily living (Novak & Mitchell, 1988). The *Occupational Therapy Practice Framework: Domain and Process* (2008) identifies sexual activity as an ADL, in conjunction with dressing, grooming, bathing, and hygiene, yet it is not routinely addressed by occupational therapists or other healthcare professionals (Hattjar, 2012). There are several reasons sexual activity is not consistently addressed by occupational therapists. Some of these reasons include: therapist discomfort with the topic; therapist lack of educational preparedness for addressing sexual activity and sexuality, and not having enough time to address the topic due to productivity demands (Hattjar, 2012). Many could argue that addressing sexual expression issues with clients is more appropriate for other professions; however, the primary core skills of occupational therapists suggest that a greater role in sexual habilitation or rehabilitation could be fulfilled instead of initially directing clients to specialist services (Couldrick, 1998a). According to Kennedy (1987), occupational therapists can assist clients with concerns in sexuality by addressing work efficiency techniques, such as energy
conservation and joint protection, as well as the use of adaptive methods and equipment.

**Student Education**

An enhancement in occupational therapy’s unique core skills is possible, but there are implications for both education and practice if sexual expression is to move from a theoretical belief to the routine of practice (Couldrick, 1999). The topic of sexual expression needs to be incorporated at an early stage of the educational process.

Sexuality is an area of occupation that is addressed in many occupational therapy programs around the world, however the degree to which it is addressed is significantly lower than many other occupations. The researchers, Payne, Green, and Corbon (1988), sent out surveys, related to sexuality education in occupational therapy departments, to 67 universities around the United States with 50 universities responding. The results of the survey showed that an average of three and a half hours of class time were devoted to sexual functioning within the occupational therapy departments. Of the respondents, 88% of the universities reported that they devoted class time to sexual functioning in their curriculum. Of the universities that reported they did not devote time to sexual functioning in their curriculum, 63% reported that there was a lack of time to cover sexual functioning, 18.2% reported sexuality functioning as a low priority, and 9.1% reported that sexual functioning “should be done elsewhere.” Sexuality should not only be covered in the classroom, but should also be covered during a student’s fieldwork; however, the degree to which sexual functioning is covered is significantly lesser than that of the classroom. In regard to occupational therapy student’s fieldwork and addressing sexual functioning with clients, of the 49 respondents to this particular
question, only 2% of the universities reported that sexual functioning was covered on fieldwork, 20.4% reported sexual functioning was not covered, and 77.6% reported they did not know (Payne et al., 1988). Fieldwork provides occupational therapy students with a hands on approach to learning, however the researchers found that sexual functioning is an area that is significantly underrepresented in an occupational therapy student’s education.

Research conducted by Neistadt (1986) found the Tufts University’s Boston School of Occupational Therapy (BSOT) dealt with the gap for the need to address sexuality concerns of clients in the clinic and the lack of formal training in the profession by offering a “module” on sexuality and disability as part of its Advanced Occupational Therapy Theory and Practice course for both graduate and undergraduate students. The goals of the module was to prepare students to provide limited sexuality counseling to clients within the scope of practice, as well as to prepare students to handle sexuality-related clinical situations appropriately. The module consisted of two sessions to equal six hours of education that addressed: anatomy, comfortableness in discussion, development, sexual acting out, counseling strategies, sexual response cycle, sexuality and disability, and neurological control. Over six years, a total of 288 students participated in this module. A post-affiliation curriculum evaluation review was conducted and indicates that 100% of the students felt the module was pertinent to their academic program at BSOT. Many students also reported using the information and skills learned through the module on level I and level II fieldwork experiences. The educational experience identified from this indicates that a sexuality and disability module can a
beneficial part of an occupational therapy curriculum to enhance the training in sexuality counseling (Neistadt, 1986).

According to Payne et al. (1988) the inconsistency between educational programs in the U.S. is attributed to the uncertain role of occupational therapists within the profession to teach clients adaptive sexual functioning. Thus, it is essential to the profession to affirm that clients’ sexual expression is a legitimate domain of concern, whereas that sexual activity is an occupational activity with the same level of importance placed on it as any other aspect of daily living that enhances quality of life (QoL) (Payne et al., 1988).

Addressing Sexual Concerns

When working with clients, occupational therapists consider the emotional aspect of engagement in activities, which is significant within the realm of sexuality and sexual activity (Hattjar, 2012). According to Hattjar (2012) the entire picture changes for an individual when a chronic disability or illness is superimposed upon sexuality or sexual activity. Any chronic condition has a unique presence attached to it for the individual on a physical and psychological level. For example, an individual may begin to feel physically undesirable or physically incapable of engaging in sexual activities. Some individuals fear that death may occur while engaging in sexual activity. Individuals may also feel that they can no longer flirt or be seductive with others due to his or her chronic condition. These concerns may lead to the individual becoming depressed, angry, or anxious about having, or not having, a significant other in his or her life or of not having the opportunity for sexual satisfaction. These issues also cause assessments and
interventions related to sexual activity to become difficult for healthcare professionals. The client may not want to address his or her concerns in regards to sexuality or sexual activity, and in return, the therapist might never approach this topic with the client. (Hattjar, 2012).

Sexual activity can be a consistent activity that provides a person with comfort and solace when living with a chronic disability, and is one of the most normal ADLs (Hattjar, 2012). Hattjar (2012) states that sexual satisfaction is an important booster of quality of life for chronically ill adults. When other common occupations are lost due to chronic illness, injury, or disability, sex and sexual activity may provide a feeling of “normalcy” or connectedness with another person (Hattjar, 2012). A perplexing issue is how healthcare professionals, along with occupational therapists, tend to place clients in a “sick role,” as an alternative to an active, engaged role relative to rehabilitation areas such as sexual activity, even though occupational therapists identify as being a “client-centered” profession (Hattjar, 2012). Hattjar (2012) defines the “sick role” as a client role that is aligned with the medical model of care in which the disease or illness is the principal focus of care. To fully engage in a holistic and client-centered approach, occupational therapists need to consider the idea that the client in the only true expert on his or her situation. Without addressing this idea of client-centeredness in evaluation and intervention two intrinsic components of being human are missed: sexuality and sexual activity (Hattjar, 2012).

How can occupational therapists and other healthcare providers address the topic of sexuality and sexual activity in a professional manner? Psychologist Jack Annon (1976) developed the PLISSIT Model as a facilitation tool in order to increase healthcare
professionals’ ability and likelihood to address sexuality and sexual activity on a regular basis with clients (Hattjar, 2012). The model, as an aid to memory, provides four levels of approach P-LI-SS-IT, as each letter or pair of letters suggests methods for handling presented sexual concerns of clients (Annon, 1976). Hattjar (2012) describes PLISSIT as an acronym that stands for *permission, limited information, specific suggestions*, and *intensive therapy*, and is further explained below:

- **P: Permission** relates to the open line of communication by the client about the topic of sexuality or sexual activity. The therapist may initiate such communication by asking the client about sexuality or sexual activity, through use of a questionnaire that includes sexuality or sexual activity in general, or by addressing the topic during the evaluation process. It is imperative that the client grants permission before any further discussion on the topic occurs.

- **LI: Limited information** or general information may be provided to the client once permission to discuss sexual activity has been granted. The therapist may provide general information to the client through one-on-one dialogue or through a review of handouts or articles. The discussion about sexuality and sexual activity should be comfortable and non-stressful for both the therapist and client.

- **SS: Specific suggestions** concerning sexual activity components is included in this section such as positioning for comfortable sex, alternative methods of sexual satisfaction in place of sexual intercourse related to the clients’ limitations or fears, and the addition of the partner within this process. The client’s partner may be included to help him or her gain an understanding of the clients’ physical and psychological situation in regards to the illness, injury, or disability, and to help
facilitate communication between the partners about sexual activity concerns or anticipated difficulties. This PLISSIT component is not generally within the scope of the profession of occupational therapy. A referral for more intensive therapy may be warranted if relationship and sexual problems persist.

- **IT: Intensive therapy** may be suggested by occupational therapists if relationship or sexual issues are ongoing. In these cases, referral to a psychologist or a licensed and certified sex therapist should occur. Occupational therapists are not sex therapists.

According to Annon (1976) use of the PLISSIT model provides several advantages for clinicians. First, this model may be utilized in a variety of settings, which means it can be adapted to each client as an individual. Also, the descending level approach of the PLISSIT Model (P-LI-SS-IT) requires an increasing level of knowledge, training, and skill on the clinician’s part. Due to each step of the model requiring increasing professional experience, it allows for clinicians to employ this approach based on his/her own level of competence. This in turn, also provides a plan for clinicians when determining when a referral elsewhere is appropriate. The most important advantage of this model is that it provides a framework for discriminating between client problems that can be addressed with brief therapy and those problems that require more intensive therapy (Annon, 1976). How many levels of the PLISSIT Model clinicians will feel competent for use will directly correspond to interest level, time devoted to increasing knowledge on the subject, training, scope of practice, and skill at each level (Annon, 1976).
Assessments

Using the PLISSIT Model opens the doors for communication with clients about sexuality or sexual concerns. Several assessments are available to help aid clinicians in the evaluation process of dealing with such concerns. The BETTER Model (Mick et al., 2003) is an acronym for healthcare professionals to Bring up sexual issues with the client, Explain that sexual function in a quality of life issue, Tell the client that resources are available, be aware of the importance of Timing in addressing sexual issues, Educate clients on how treatment received might affect their sexual functioning, and Record the intervention (Hattjar, 2012). This model is broken down by Hattjar (2012) as the following:

- **B**: Bring up intimacy issues along with other issues regarding ADLs, as it gives the client assurance that sexual concerns are acceptable to discuss.
- **E**: Explain verbally that sexuality is a normal part of daily living. Normalizing the topic helps the client to feel more comfortable.
- **T**: Tell the clients that you, as a clinician, are prepared to offer resources and information on the topic to address his or her concerns about sexual functioning. This will encourage clients to accept the information presented and ask further questions that might aid in improving his or her situation.
- **E**: Educate the client on changes he/she may be experiencing in sexual functioning as a result of their treatment. For example, a client may be unaware of the sexual side effects of cancer treatment.
- **R**: Recording some notes may be beneficial to assist the clinician in remembering to check back in with the client about progress made in restoring his or her sexual
functioning. It is important to maintain as much privacy as possibly in these notes, and to remember extensive notes are not necessary.

It is apparent there is some overlap with the PLISSIT Model and the BETTER model, as both address several key issues. Hattjar (2012) notes the overlap includes the issues of (1) normalizing the topic of sexuality as appropriate for discussion, (2) providing client education, and (3) offering suggestions for improving sexual functioning. Both models also place importance on other resources being available, although with much more focus on this area in the BETTER Model with some specific statements to use, whereas, the PLISSIT Model is more open-ended. The BETTER Model also suggests the importance of timing and specifically recognizes sexual functioning as a QoL issue. The differences between the two models are not significant enough to recommend one over the other; therefore, preference of use should be determined by comfort level of the clinician (Hattjar, 2012).

If a client indicates further interest in discussing sexual issues, the occupational therapist may choose from several approaches to obtain a more detailed assessment of the concerns. A conversational approached may be utilized, or use of the Kingsberg Brief Assessment (Kingsberg, 2006), to assess client concerns about sexuality (as cited in Hattjar, 2012). The Kingsberg (2006) questions are brief and open-ended, allowing for clients to expand on answers beyond a simple “yes” or “no” (Hattjar, 2012). This assessment is more specific in its questions to acquire more details about the client’s sexual problems if concern is expressed. Use of this assessment by occupational therapists will depend on personal comfort levels.
As a therapist, it is also important to incorporate the psychosocial aspect of assessment, to assess whether clients have concerns about depression or anxiety that can play a role in his or her overall functioning, which includes sexual functioning (Hattjar, 2012). According to Hattjar (2012) if symptoms of depression are apparent, administration of the Beck Depression Inventory, 2nd Edition (BDI-II; Beck, Steer & Brown, 1996) should be done. This is a 21-item, self-report rating inventory that measures attitudes and symptoms of depression in adolescents and adults. The BDI-II is often used as an indicator of the severity of depression, but is not to be used as a diagnostic tool. The tool has been studied for evidence of its reliability and validity across varying populations and cultural groups (Beck, Steer & Brown, 1996). If symptoms of anxiety are present, administer the Burns Anxiety Checklist (Burns, 1999) (Hattjar, 2012). Both of these assessments are used to determine the degree that these psychosocial issues affect the client, and the client’s involvement in sexual activity and his or her sense of sexuality and gender (Hattjar, 2012).

In concurrence with the occupational therapy evaluation, a sexuality questionnaire can be utilized to provide information concerning sexual activity in general, psychosocial status, physical abilities and limitations, personal values, and communication abilities, all of which encompass the subject matter of sexual activity and sexuality (Hattjar, 2012, p. 89). The questionnaires should be used as a supplemental data-gathering tool to enhance the occupational therapy evaluation. Two questionnaires that can be used in conjunction with the occupational therapy evaluation and assessment include: Multidimensional Sexuality Questionnaire (MSQ; Snell, Fisher & Walters, 1993), and Trueblood Sexual Attitudes Questionnaire (TSAQ; Trueblood, Hannon & Hall, 1998) (as cited in Hattjar,
The MSQ (Snell et al., 1993) was developed to gain information about the psychological tendencies associated with human sexuality through a multidimensional measure. This questionnaire has 61 questions with an alphabetized Likert-response scale, which can then be used throughout the occupational assessment process (Snell et al., 1993). The TSAQ (Trueblood et al., 1998) was developed to measure attitude change in regards to the most common covered topics in a human sexuality college course. The questionnaire consists of 80 questions that are placed on one of five major subscale topics: (1) autoeroticism, (2) heterosexuality, (3) homosexuality, (4) sexual variations, and (5) commercial sex. Each question is rated on a 9-point Likert scale, and can provide some information during the occupational therapy assessment.

**Perspectives on Competency and Comfort Level**

The study conducted by Payne, Green, and Corbin (1988), shows that sexuality or sexual functioning is not addressed in an occupational therapy student’s education to a high degree, which has the potential for a significant impact on a student’s level of competence and confidence in regards to addressing sexuality with clients. A survey was conducted by Jones, Weerakoon, and Pynor (2005), where 340 students in an undergraduate occupational therapy program were asked to complete the Comfort Scale Questionnaire. The Comfort Scale Questionnaire consists of 19 questions related to the comfort level to different sexual situations. The results of the survey showed a high level of discomfort for many of the questionnaire items with students reporting that their occupational therapy program had not prepared them enough to deal with the specific sexual situations listed in the questionnaire. The scenarios on the questionnaire that
caused the highest level of discomfort were walking in on a client who was masturbating and dealing with a client who makes an overt sexual remark. The scenarios on the questionnaire that caused the lowest level of discomfort were working with a homosexual male as a client and a 14-year old female who was seeking information on contraception.

The results showed that the students did not feel they were prepared enough for 18 out of the 19 questions on the Comfort Scale Questionnaire (Jones, Weerakoon, & Pynor, 2005).

The survey conducted by Weerakoon and Pynor (2005), shows that undergraduate occupational therapy students do not feel that their occupational therapy program prepared them enough to be competent enough or confident enough to deal with sexual scenarios related to working with a client. The evidence shows that occupational therapy students lack competence and confidence in regards to sexual situations with clients, which has a direct impact on the levels of competence and confidence for practicing occupational therapists. There are many factors that come into play when discussing comfort levels of occupational therapists in regards to sexuality. One of the first factors in feeling comfortable with discussing sexuality with clients is to first feel comfortable with one’s own sexuality and then progress to achieving comfort with discussing sexuality with clients (Neistadt, 1986). Analysis from a focus group on occupational therapists dealing with sexual situations with clients showed that awareness of one’s own values and beliefs about sexuality and how they impact the therapist’s relation to the clients was a very important aspect when discussing sexuality (Yallop & Fitzgerald, 1997). The focus group conducted by Yallop and Fitzgerald (1997) also found that the greatest factor in a low level of comfort when discussing sexuality with clients was a lack
of knowledge and experience. In a study conducted by Novak and Mitchell (1988), 74 occupational therapists and 76 rehabilitation nurses were surveyed in regards to sexuality counseling with spinal cord patients in a rehabilitation center, with a lack of knowledge being a major factor in relinquishing responsibility for sexual counseling with clients. 51.7% of the occupational therapists and 68% of the rehabilitation nurses reported having some form of educational training in regards to sexuality with only 37% of occupational therapists and 60% of rehabilitation nurses actually providing sexuality counseling to their clients (Novak & Mitchell, 1988). The research shows that sexuality is not routinely addressed with clients for many factors, however if occupational therapists want to provide a holistic and client-centered approach to therapy, they cannot ignore that sexuality is a vital human experience (Sakellariou & Algado, 2006).

Discussion of sexuality in a clinical setting does not only have impact on the comfort level for occupational therapists and students but also for clients themselves. In a qualitative study conducted by McAlonan (1995), 12 individuals with spinal cord injuries were interviewed in regards to sexual rehabilitation services received. Eleven out of the 12 participants reported that they received some sort of education on sexual rehabilitation, however the majority of the participants also reported dissatisfaction with the services they received. The participants of the study reported that many factors come into play in regards to the client’s receptiveness, confidence, and level of satisfaction with services received on sexual rehabilitation and included: the therapist’s style of presentation, body language, affect, attitude, and personal level of comfort (McAlonan, 1995). In another study conducted by Taylor (2011), 13 individuals with motor neuron disease and their partners were interviewed in regards to their experiences of sexuality
and intimacy and none of the participants reported that any healthcare professional, including occupational therapists, addressed the issue of sexuality. Studies show there is a significant lack of information given to clients in regards to sexuality as well as dissatisfaction with the services that are provided for sexuality. This information implies an increase in knowledge, experience, and comfort levels with sexuality needs to be addressed with occupational therapists and occupational therapy students in order to treat clients in a holistic and client-centered manner.

Gaps in the Literature

According to Esmail, Darry, Walter and Knupp (2010) prior to the 1970’s, minimal research was conducted on sexuality and disability. The topic of sexuality was traditionally considered personal and private, therefore, not a necessary component of rehabilitation. Any research that did focus on human sexuality was done strictly from a medical perspective (Esmail et al., 2010). Couldrick (1998a) summarized the increase in openness toward understanding sexuality in the western world, which began to emerge in the 1970’s as healthcare professionals began to recognize sexual rehabilitation as an important aspect of the entirety of the rehabilitation process. Moving into the 1980’s, core texts began to acknowledge the importance of sexual issues in rehabilitation and the potential role for occupational therapists in addressing them. These authors implied that sexuality was an essential domain of concern for occupational therapists to consider in regard to the psychosocial or physical aspects of therapy when working with adolescents, adults, or elderly people (Couldrick, 1998a). Neistadt (1993) suggested: “As holistic
caregivers dedicated to facilitating quality lives, occupational therapists should be prepared to address sexuality issues with their adolescent and adult patients.”

However, through an extensive search of the literature on whether or not sexuality and sexual functioning is being addressed in occupational therapy, it remains unclear from the professional literature or from practice if these topics are universally accepted aspects of the occupational therapy. Even within models of practice and frames of reference, which help to guide occupational therapy practice, there is debate about whether to include sexuality as an occupation. The Model of Human Occupation, by Keilhofner (1993), specifically excludes sexual expression. Keilhofner (1993) believed that sexual activity was not primarily occupational in nature due it being rooted in the biological requirements of the individual. In contrast, the Canadian Occupational Performance Model (1991) incorporates sexual needs into the physical component of the individual. The model Adaptation through Occupation (Reed and Sanderson, 1992) eventually incorporated sexual expression, in the performance area of self-care, which was absent in earlier editions. Couldrick (1999) found within her own study and in four comparative studies, on occupational therapists’ attitudes on sexuality, that no one rejected sexual activity as a part of a person’s occupational nature. In the study by Couldrick (1999) the majority of occupational therapists who participated equated sexual behavior with other activities of daily living, and therefore reasoned it could not be excluded from therapy. This viewpoint appears to counter Keilhofner’s belief outlined throughout his Model of Human Occupation.

Despite some research indicating the importance of sexuality, it is often ignored in occupational therapy. According to Sakellariou and Algado (2006) confusion about the
connection with occupation and the importance to the individual may be one reason why sexuality is left out of the research. With the recent renewal within the profession to provide holistic and client-centered care to clients, therapists cannot exclude integral identity components, such as sexuality, from therapy treatment. Failure to address sexuality as an integral part of the client could compromise therapy and lead to suboptimal therapeutic encounters and outcomes (Sakellariou & Algado, 2006). Through the research, it is evident there is an increasing recognition of the importance that expression of sexuality plays in the quality of life of individuals.

Limitations

Studies have shown the importance of sexuality in healthcare, however there is a significant dearth of literature and research in relation to occupational therapy and sexuality (Yallop & Fitzgerald, 1997). This discrepancy creates a grey area in regard to the roles occupational therapists play in addressing sexuality, as well as the specific techniques and interventions used in therapy. Another limitation of sexuality being addressed during occupational therapy is the amount of time occupational therapists are able to spend with clients. According to McAlonan (1996), the current structure in the healthcare system has limited the amount of time occupational therapists are able to spend with their clients, which results in a focus on more intensive areas for clients and not on sexuality. Furthermore, a search of the American Occupational Therapy Association (AOTA) website demonstrated a lack of continuing educational courses on the topic of sexuality available for practicing occupational therapists, which could contribute to the diminished comfort level reported by the majority within the profession.
AOTA has published several continuing education papers within the last few years addressing the topic of sexuality and the role it plays in occupational therapy. In 2008, the OT Practice magazine published, *Let’s Talk About Sex*, by Lindsay Miller. In 2008, AOTA also published a continuing education article on the topic of sexuality titled, *Addressing Sexuality With Adult Clients With Chronic Disabilities: Occupational Therapy’s Role*, by Hattjar, Parker and Lappa. The most recent paper is a fact sheet by MacRae (2013) entitled *Sexuality and the Role of Occupational Therapy*. MacRae (2013) emphasizes how sexuality is a humanistic characteristic that should be addressed in therapy, and provides several ideas for occupational therapists to use as a part of the intervention process.

**Summary**

Sexuality is a broad term that can be used to encompass other terms such as sexual expression and sexual functioning and can be defined as a holistic concept of the individual that is more than just physical sexual behavior but also relates to thoughts and feelings of everyday life (Couldrick, 1998a). The *Occupational Therapy Practice Framework: Domain and Process* (2008) identifies sexual activity as an ADL, but the literature shows occupational therapists and other healthcare professionals do not routinely address it due to lack of education or comfort with the subject. After an extensive search regarding the topic of sexuality within the profession of occupational therapy it was found that much of the limited literature stems from the late 1980’s to early 1990’s, yet the literature from the 2000’s continue to address the same issues. It is apparent that education for occupational therapists on addressing sexuality and sexual
concerns with clients needs to begin in the early stages of professional education. Research continues to show inconsistencies between educational programs in the U.S. due to the uncertain role of occupational therapists to teach clients about sexual functioning. Despite the uncertainties, several evaluation and assessment tools have been developed to aid occupational therapists in addressing sexuality with clients. If occupational therapists strive to be holistic healthcare providers, then sexuality as an ADL needs to be addressed on a more consistent basis.

Due to the reported low levels of comfort for occupational therapy students and practitioners regarding sexuality and the role occupational therapists play in addressing the subject with clients, the following product was developed. The product includes lessons plans, with varying lectures and activities, to be incorporated into several courses throughout the duration of an occupational therapy professional program. The goal of this product is to increase exposure to issues of sexuality and sexual functioning throughout the curricula of a Midwestern professional occupational therapy program in order to create competent and comfortable practitioners within the field.
CHAPTER III

METHODOLOGY

Sexuality is a part of life that all individuals experience in one dimension or another. When an individual is experiencing an illness or injury it has the ability to impact many different areas of a person’s life, including one’s sexual functioning or sexuality. The role of occupational therapy is to assist individuals in achieving their highest level of independence in regards to meaningful occupations including sexuality (Novak & Mitchell, 1988). Occupational therapy plays a role in addressing sexuality concerns of clients as listed in the *Occupational Therapy Practice Framework: Domain and Process* (2008), however it is an area that is not frequently addressed in practice. According to Couldrick (1998a), sexuality was an essential domain of concern for occupational therapists to consider in regard to the psychosocial or physical aspects of therapy when working with adolescents, adults, or elderly people. Through the research, it is evident that many agree that occupational therapy plays a role in addressing sexual concerns, however little research is done to justify these statements. Sakellariou and Algado (2006) relate this lack of research on sexuality and occupational therapy to confusion about the connection with occupation and the importance to the individual.

Occupational therapy students as well as practicing occupational therapists are reluctant to address sexuality for many different reasons including: therapist discomfort with the topic; therapist lack of educational preparedness for addressing sexual activity
and sexuality, and not having enough time to address the topic due to productivity demands (Hattjar, 2012). Of the reasons for discomfort with addressing sexuality listed above, the lack of education is the most commonly identified in research. In a survey conducted by Weerakoon and Pynor (2005), the data shows that undergraduate occupational therapy students do not feel that their occupational therapy program prepared them enough to be competent enough or confident enough to deal with sexual scenarios related to working with a client. The lack of education in occupational therapy programs has a direct impact on the comfort level of practicing occupational therapists as well. A focus group conducted by Yallop and Fitzgerald (1997) also found that the greatest factor in a low level of comfort for practicing occupational therapists when discussing sexuality with clients was a lack of knowledge and experience. Due to this reported lack of knowledge and experience, the authors of this scholarly project felt it was important to develop a series of educational sessions and activities for students related to sexuality and sexual scenarios with clients. The purpose of these educational activities is to assist students enrolled in an occupational therapy program to create a better understanding of the impact that illness or injury can have on sexual functioning, to identify appropriate ways to address sexual scenarios with clients, specific strategies or interventions related to sexual functioning, addressing gender identity and sexual orientation with clients, as well as addressing personal beliefs and values related to sexuality. The educational activities will also provide the opportunity for students to become more comfortable with their own sexuality and in turn more comfortable with discussing the topic of sexuality with clients.
A review of literature and research was conducted to collect information on sexuality and the role of occupational therapy on the topic of sexuality. Several search engines were used throughout the process to acquire journal articles and included: PubMed, CINHAL, and Psych Info. Journal articles were obtained through the university online library and the book *Sexuality and Occupational Therapy: Strategies for Persons with Disabilities* was also utilized. This scholarly project was developed due to the research indicating a lack of comfort and knowledge in addressing sexuality with clients in a practice setting. Assessments were identified through research to aid occupational therapists in the evaluation process of sexual concerns, as well as opening the door for communication between clients and therapists related to sexuality.

The product of this scholarly project is a series of educational activities and sessions for students to gain knowledge and gain a comfort with the topic of sexuality and addressing the topic in a clinical setting. Copies of lectures were obtained from occupational therapy faculty and were utilized to create additional educational activities. These activities were created to improve the competency and comfort level of students in addressing sexual concerns.

The educational lesson plans were developed by incorporating the model of Occupational Adaptation. Occupational Adaptation is a model that enables an individual to adapt to and learn from his or her experiences and equips him or her more strongly to adaptively respond to future occupational challenges (Turpin & Iwama, 2011). This model focuses on the internal adaptive response of the learner or client, which leads to the ability to generalize through the use of memory and reflection (Turpin & Iwama, 2011). Occupational Adaptation is utilized to structure the educational lesson plans in
order to allow the learner to evaluate his or her response of addressing sexual concerns with clients and to internally adapt future responses based on the memory and reflection of specific information and/or interventions in which positive outcomes were seen or discussed. The Occupational Adaptation model also allows the learner to generalize these adaptation responses to other forms of content and educational information in order to become a competent health care provider.
CHAPTER IV
THE PRODUCT

Purpose

The primary core skills of occupational therapists suggest that a greater role in sexual habilitation or rehabilitation could be fulfilled instead of initially directing clients to specialist services (Couldrick, 1998a). Occupational therapists strive to be holistic in care, which includes consideration of the emotional aspect of engagement in activities, which is significant within the realm of sexuality and sexual activity (Hattjar, 2012). However, through an extensive search of the literature on whether or not sexuality and sexual functioning is being addressed in occupational therapy, it remains unclear from the professional literature or from practice if these topics are universally accepted aspects of the occupational therapy. According to Sakellariou and Algado (2006) confusion about the connection with occupation and the importance to the individual may be one reason why sexuality is left out of the research.

After searching the literature regarding the topic of sexuality within the profession of occupational therapy it was found that much of the limited literature stems from the late 1980’s to early 1990’s, yet the literature from the 2000’s continue to address the same issues. Based on the findings through the literature review process it was found that OT students and practitioners are not comfortable discussing the subject of sexuality with clients.
Due to the consistently reported low levels of comfort for occupational therapy students and practitioners throughout decades of research regarding sexuality and the role occupational therapists play in addressing the subject with clients, a product was developed (complete product found in the Appendicies). The purpose of this product is to increase exposure to issues of sexuality and sexual functioning comprehensively throughout the curricula of a Midwestern professional occupational therapy program in order to create knowledgeable and comfortable entering practitioners within the field.

Description

The product, a series of lesson plans, was designed in accordance with the 2011 Accreditation Council for Occupational Therapy Education (ACOTE) standards. A review of these standards was conducted for each core course of the Midwestern occupational therapy program to see where lesson plans for the topic of sexuality or sexual functioning appropriately fit into the current curriculum. After the review of the curriculum it was determined that increased exposure and innovative lesson plans addressing sexuality would be beneficial in seven of the core courses. The majority of the courses selected included some aspect of addressing the topic of sexuality; however, lesson plans were created for these courses to enhance exposure and increase learning opportunities for the students. Other courses were identified as not addressing the issue of sexuality at all, so lesson plans were developed in order to created a more comprehensive and sequential curriculum. The following are the seven core courses, in sequential order, identified as appropriate to address the topic of sexuality or sexual functioning:
• OT 423: Neuroscience
• OT 426: Personal Professional Development
• OT 430: Psychosocial Aspects of OT With Children, Adolescents, and Young Adults
• OT 451: Multicultural Competency in OT
• OT 453: Physical Aspects of OT With the Maturing Adult
• OT 454: Gerontic Occupational Therapy
• OT 456: Psychosocial Aspects of OT With the Maturing Adult

The learning activities were designed to enhance the learning experiences and increase exposure to the topic of sexuality for the students. The lesson plans can be implemented into the courses with discretion of the faculty member teaching the course.

Theoretical Model

Within the Midwestern professional occupational therapy program, the students are encouraged to take responsibility for learning. This guiding principle is part of the Occupational Adaptation (OA) model. The OA model allows each person to master and respond adaptively to various occupational challenges encountered in life in order to respond to future occupational challenges (Turpin & Iwama, 2011). A developmental process is presumed where occupation readiness skills in the person subsystems (sensory, cognitive, and psychosocial) set the stage for interaction in the environmental contexts of work, play, and leisure (Schkade & McClung, 2001). The learners (the students) become the agent of change in relation to acquisition of professional knowledge to increase personal comfort and competence for addressing the topic of sexuality with clients.
According to the Student Manual (2011) the intent of the Midwestern occupational therapy program is to develop students capable of assisting individuals to both assume the roles appropriate to their developmental position and to adapt to the challenges inherently present at each point in the developmental process with the common goal of competence in occupational functioning. Sexuality is an aspect of being human that spans across the lifetime, where challenges may occur at any stage.

It is hoped that through use of this product, it will enhance the occupational therapy students’ learning experience and increase competence, resulting in practitioners who are able to assist clients in engaging in all aspects of meaningful occupation. In accordance with the OA model, the goal of this product is to engage students as active learners through engagement in occupational learning activities in regard to addressing sexuality and sexual functioning with clients with regular challenges toward personal, academic and professional growth. The lesson plans can be adjusted by the educators in response to the student’s level of mastery on the subject. Where the lesson plans begin with some lecture to inform the students about the topic, the lessons then become more discussion based and students are encouraged to look within themselves for how they feel and perceive sexuality and sexual functioning. The basis for the activities then becomes for the students to take the lead to learn and become the agent of change within himself or herself to gain competency and confidence with addressing the subject of sexuality with clients. With the OA Model guiding this process, students are expected to acquire the tools to not only assist clients with adaptive processes across the lifespan but also to enable client participation in valued occupations, such as the ADL of sexuality.
Product

The authors have created a series of lesson plans (learning activities) to address the topic of sexuality and sexual functioning. These lesson plans are designed to be incorporated sequentially to build knowledge and comfort throughout the curriculum of a Midwestern professional occupational therapy program. The lesson plans were developed and/or adapted to be integrated into courses that did not cover the topic of sexuality or used to enhance the current curricula of courses that did address the topic, which included the seven specific courses. Some lesson plans were adapted with permission from the current faculty members, or from other resources. The lesson plans include a variety of lectures, readings and interactive activities to increase exposure, comfort level and competence for students when discussing sexuality and sexual functioning concerns with clients, while on fieldworks and as entering practitioners. The interactive activities include such things as games, case studies, videos, and group discussion.

The learning activities in the first two courses (OT 423 and OT 426) are the basis for the rest of activities throughout the program regarding sexuality. The lesson plans focus on physiology terminology, desensitization of sexual terms, and identification of personal beliefs and values about sexuality. As the courses progress the learning activities maintain aspects of the previous course objectives, but evolve into how to appropriately address the topic with clients while feeling comfortable and competent as a therapist. Topics involved with addressing sexuality include: evaluation, intervention, stereotypes, abuse, age, personal beliefs, medical diagnoses, mental health, sexual orientation, positioning, and adaptive equipment.
Conclusion

The *Occupational Therapy Practice Framework: Domain and Process* (2008) describes the domain of practice as “supporting health and participation in life through engagement in occupations” (AOTA, 2008, p. 626). To be a holistic occupational therapist all aspects of the client’s life must be taken into account within the evaluation and intervention process, which includes sexuality and sexual functioning. The primary core skills of occupational therapists to facilitate holistic and quality of life care among clients suggests they should be prepared to address sexuality issues with each client (Couldrick, 1998a).

The American Occupational Therapy Association considers sexuality an activity of daily living; therefore, addressing sexual concerns with clients is within the realm of occupational therapy practice. However, occupational students and practitioners continue to report a lack of competence and education in addressing the topic with clients. It is often a topic that is neglected or passed on to other healthcare professionals. Through use of this product, occupational therapy students will gain the necessary information, experience, exposure, and competence to use their skills to addresses sexuality with clients once in practice.

Chapter V culminates with the summary of literature findings, conclusions and the authors’ recommendations for future research and implementation of the product within a professional occupational therapy program.
CHAPTER V
SUMMARY

The series of educational lesson plans are intended to increase the confidence and competence levels of occupational therapy students to address sexuality concerns in a clinical setting. Occupational therapy’s role is that of assisting patients in achieving an optimal level of independence in regards to meaningful occupations including sexual activity and other activities of daily living (Novak & Mitchell, 1988). Although sexual activity is an activity of daily living that occupational therapists have the ability to address, it is not an area that routinely gets addressed due to several reasons. According to Hattjar (2012), occupational therapists do not address sexual activity routinely due to: therapist discomfort with the topic; therapist lack of educational preparedness for addressing sexual activity and sexuality, and not having enough time to address the topic due to productivity demands. The lesson plans will provide students with information on the different ways that physical and/or mental illness can impact sexuality, gender identity and sexual orientation, personal values and cultural customs related to sexuality, as well as specific interventions to address specific sexual concerns. The lesson plans will also allow students the opportunity to open up communication with clients about sexual concerns they may have and provide the students with a higher comfort level in discussion of different sexual scenarios a client may bring up.
The lesson plans are designed to be implemented into seven different courses and each lesson plan is structured to build upon one another throughout the course of completion of the occupational therapy program. Instructors will be provided with lesson plans that include educational information and interactive activities related to sexuality and occupational therapy, as well as potential discussion questions related to each lesson plan. All students should be able to more effectively address areas of concern related to sexuality in a clinical setting and in turn increase the quality of life of their future clients. It is recommended to implement these lesson plans into a university’s occupational therapy curriculum and then to utilize a pretest-posttest study from year one of the program to year three of the occupational therapy program to evaluate the effectiveness of the lesson plans. The Comfort Scale Questionnaire (Jones, Weerakoon, Pynor, 2005) and/or the survey created by University of North Dakota Occupational Therapy Department alumni and faculty (Farkas & Reynolds, 2013) could be utilized as comfort and competency surveys in the suggested pretest-postest study. It is also recommended that the occupational therapy program purchase the following assessments to allow students to have a hands on approach of using a sexuality assessment for future clients: Kingsberg Brief Assessment (Kingsberg, 2006), Beck Depression Inventory, 2nd Edition (BDI-II; Beck, Steer, & Brown, 1996), Burns Anxiety Checklist (Burns, 1999), Multidimensional Sexuality Questionnaire (MSQ; Snell, Fisher & Walters, 1993), and Trueblood Sexual Attitudes Questionnaire (TSAQ; Trueblood, Hannon & Hall, 1998) (as cited in Hattjar, 2012).

Recommendations for the future include updating the lesson plans with current research as it becomes available. The research revealed that sexuality is an activity of
daily living that does not get addressed by occupational therapists as often as it should, due to a lack of knowledge and comfort by practicing occupational therapists. Due to the limited documented evidence provided from the literature review, future research is needed in regards to occupational therapy and its role in sexuality. Future studies could focus on the impact sexuality education modules have on occupational therapy students and practicing occupational therapists, the impact of sexuality interventions on clients in relation to quality of life, and the impact of societal stigmas on addressing sexuality in occupational therapy and other areas of health care.
REFERENCES


Student manual. (2011). Occupational Therapy Department, University of North Dakota, Grand Forks.


The lesson plans may be incorporated into the existing course curricula with the discretion of the instructor. There are two learning activities included.

1. Sexual Development Through the Life Cycle
2. “Down There” Bingo
Sexual Development through the Life Cycle
A Lesson Plan from Life Planning Education: A Youth Development Program

Many people cannot imagine that everyone—babies, children, teens, adults, and the elderly—are sexual beings. Some believe that sexual activity is reserved for early and middle adulthood. Teens often feel that adults are too old for sexual intercourse. Sexuality, though, is much more than sexual intercourse and humans are sexual beings throughout life.

Sexuality in infants and toddlers—Children are sexual even before birth. Males can have erections while still in the uterus, and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Little boys and girls can experience orgasm from masturbation although boys will not ejaculate until puberty. By about age two, children know their own gender. They are aware of differences in the genitals of males and females and in how males and females urinate.

Sexuality in children ages 3-7—Preschool children are interested in everything about their world, including sexuality. They may practice urinating in different positions. They are highly affectionate and enjoy hugging other children and adults. They begin to be more social and may imitate adult social and sexual behaviors, such as holding hands and kissing. Many young children play "doctor" during this stage, looking at other children's genitals and showing theirs. This is normal curiosity. By age five or six, most children become more modest and private about dressing and bathing.

Children of this age are aware of marriage and understand living together, based on their family experience. They may role-play about being married or having a partner while they "play house." Most young children talk about marrying and/or living with a person they love when they get older. School-age children may play sexual games with friends of their same sex, touching each other's genitals and/or masturbating together. Most sex play at this age happens because of curiosity.

Sexuality in preadolescent youth ages 8 to 12—Puberty, the time when the body matures, begins between the ages of nine and 12 for most children. Girls begin to grow breast buds and public hair as early as nine or 10. Boys' development of penis and testicles usually begins between 10 and 11. Children become more self-conscious about their bodies at this age and often feel uncomfortable undressing in front of others, even a same-sex parent.

Masturbation increases during these years. Preadolescent boys and girls do not usually have much sexual experience, but they often have many questions. They usually have heard about sexual intercourse, petting, oral sex, and anal sex, homosexuality, rape and incest, and they want to know more about all these things. The idea of actually having sexual intercourse, however, is unpleasant to most preadolescent boys and girls.
Same-gender sexual behavior is common at this age. Boys and girls tend to play with friends of the same gender and are likely to explore sexuality with them. Masturbating with one's same-gender friends and looking at or caressing each other's genitals is common among preadolescent boys and girls. Such same-gender sexual behavior is unrelated to a child's sexual orientation.

Some group dating occurs at this age. Preadolescents may attend parties that have guests of both genders, and they may dance and play kissing games. By age 12 or 13, some young adolescents may pair off and begin dating and/or "making out."

Sexuality in adolescent youth (ages 13 to 19)- Once youth have reached puberty and beyond, they experience increased interest in romantic and sexual relationships and in genital sex behaviors. As youth mature, they experience strong emotional attachments to romantic partners and find it natural to express their feelings within sexual relationships. There is no way to predict how a particular teenager will act sexually. Overall, most adolescents explore relationships with one another, fall in and out of love, and participate in sexual intercourse before the age of 20.

Adult sexuality—Adult sexual behaviors are extremely varied and, in most cases, remain part of an adult's life until death. At around age 50, women experience menopause, which affects their sexuality in that their ovaries no longer release eggs and their bodies no longer produce estrogen. They may experience several physical changes. Vaginal walls become thinner and vaginal intercourse may be painful as there is less vaginal lubrication and the entrance to the vagina becomes smaller. Many women use estrogen replacement therapy to relieve physical and emotional side effects of menopause. Use of vaginal lubricants can also make vaginal intercourse easier. Most women are able to have pleasurable sexual intercourse and to experience orgasm for their entire lives.

Adult men also experience some changes in their sexuality, but not at such a predictable time as with menopause in women. Men's testicles slow testosterone production after age 25 or so. Erections may occur more slowly once testosterone production slows. Men also become less able to have another erection after an orgasm and may take up to 24 hours to achieve and sustain another erection. The amount of semen released during ejaculation also decreases, but men are capable of fathering a baby even when they are in their 80's and 90's. Some older men develop an enlarged or cancerous prostate gland. If the doctors deem it necessary to remove the prostate gland, a man's ability to have an erection or an orgasm is normally unaffected. Recently, There are medications to help older men achieve and maintain erections.

Although adult men and women go through some sexual changes as they age, they do not lose their desire or their ability for sexual expression. Even among the very old, the need for touch and intimacy remains, although the desire and ability to have sexual intercourse may lessen.
Discussion Questions:
• How do you define sexuality?
• How do you think sexuality changes throughout the lifespan?
• What are some stereotypes about sexuality throughout the lifespan that you have heard?
• Discuss how parents, peers, schools, textbooks, television contribute to gender role stereotypes.
• Discuss reasons why sexual attitudes have become more liberal in recent years.

http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/201?task=view
“Down There” Bingo

A classic game becomes a learning tool by using health concepts and words instead of numbers.

**Materials:** Homemade Bingo cards, each containing a grid of at least nine squares. Each square contains a reproductive health term, e.g. penis, vulva, vagina, intercourse, erection, ejaculation, orgasm. There should be more overall terms than squares on the cards. Every Bingo card should have the same number of squares, but a different arrangement and subset of terms.

Each term should also be individually written on its own small card. These are the cards to pick from the Bingo basket (or hat or pot).

Pebbles, beads, stones or some kind of markers are necessary to use on the Bingo cards.

**Play:** Each player gets at least one Bingo card. The basket of terms is then passed around and each player has a turn blindly picking out a card and reading it aloud to the group. If appropriate, have players shout out the term loudly, say it several times, or have the whole group repeat the word joyfully in unison. Also, have the group say aloud any slang words they know for the term. Any players that have that term on their card cover it with a marker.

The first player to cover up a complete row (up, down or diagonal) or to cover their entire board shouts “Down There Bingo” and wins. Play can continue until all players have gotten Bingo. The last player left can be given a prize too!

**Discussion:**

- What are some slang terms you have heard for these words?
- Why do people use these terms?
- Which slang names are positive or negative?
- Do people use slang for other parts of their body?

The following BINGO cards are examples and can be altered to develop numerous cards for play.

Adapted with permission from Program for Appropriate Technology in Health (PATH), 2002

[www.path.org](http://www.path.org)
"DOWN THERE"
B.I.N.G.O

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<td>SEMINAL VESICLES</td>
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<td>ORAL SEX</td>
<td>FREE SPACE</td>
<td>AMENORRHEA</td>
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"DOWN THERE"
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<td>ANUS</td>
<td>ORAL SEX</td>
<td>FREE SPACE</td>
<td>MASTURBATE</td>
<td>PROSTATE GLAND</td>
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<tr>
<td>SPERM</td>
<td>ZYGOTE</td>
<td>VULVA</td>
<td>GAMETE</td>
<td>ANDROGENS</td>
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<tr>
<td>TESTICLES</td>
<td>SEMINAL VESICLES</td>
<td>GONORRHEA</td>
<td>AROUSAL</td>
<td>ASPERMIA</td>
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### Possible Terms and Definitions

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tr>
<td>Androgen</td>
<td>A male sex hormone, such as testosterone</td>
</tr>
<tr>
<td>Anus</td>
<td>The opening at the end of the alimentary canal through which solid waste matter leaves the body</td>
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<tr>
<td>Amenorrhea</td>
<td>An abnormal absence of menstrual periods for 3 or more months</td>
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<tr>
<td>Arousal</td>
<td>The action or fact of arousing or being aroused</td>
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<tr>
<td>Aspermia</td>
<td>Failure to produce semen, or absence of sperm in the semen</td>
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<tr>
<td>Circumcision</td>
<td>The surgical removal of the foreskin of the penis</td>
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<tr>
<td>Clitoris</td>
<td>An organ of sensitive, erectile tissue located anterior to the urethral meatus and the vaginal orifice</td>
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<tr>
<td>Erection</td>
<td>An enlarged and rigid state of the penis, typically in sexual excitement</td>
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<tr>
<td>Fallopian Tubes</td>
<td>Tubes which extend from the upper end of the uterus to a point near, but not attached to, an ovary</td>
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<tr>
<td>Gamete</td>
<td>A mature haploid male or female germ cell that is able to unite with another of the opposite sex in sexual reproduction to form a zygote</td>
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<tr>
<td>Gonads</td>
<td>An organ that produces gametes; a testis or ovary</td>
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<tr>
<td>Gonorrhea</td>
<td>A highly contagious condition caused by the bacterium Neisseria gonorrhoeae</td>
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<tr>
<td>Hormone</td>
<td>A regulatory substance produced in an organism and transported in tissue fluids such as blood or sap to stimulate specific cells or tissues into action</td>
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<tr>
<td>Impotence</td>
<td>The inability of the male to achieve or maintain a penile erection; also known as erectile dysfunction</td>
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<tr>
<td>Infertility</td>
<td>The inability of a couple to achieve pregnancy after 1 year of regular, unprotected intercourse, or the inability of a woman to carry a pregnancy to live birth</td>
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<tr>
<td>Intercourse</td>
<td>Sexual contact between individuals involving penetration, esp. the insertion of a man's erect penis into a woman's vagina, typically culminating in orgasm and the ejaculation of semen</td>
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<tr>
<td>Masturbate</td>
<td>Stimulate one's own genitals for sexual pleasure</td>
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<tr>
<td>Menopause</td>
<td>The normal termination of the menstrual function</td>
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<tr>
<td>Oocyte</td>
<td>A cell in an ovary that may undergo meiotic division to form an ovum</td>
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<tr>
<td>Oral Sex</td>
<td>Sexual activity in which the genitals of one partner are stimulated by the mouth of the other; fellatio or cunnilingus</td>
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<tr>
<td>Orgasm</td>
<td>A climax of sexual excitement, characterized by feelings of pleasure centered in the genitals and (in men) experienced as an accompaniment to ejaculation</td>
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<tr>
<td>Ovaries</td>
<td>A pair of small, almond-shaped organs located in the lower abdomen, one on either side of the uterus</td>
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<tr>
<td>Priapism</td>
<td>A painful erection that last 4 hours or more but is not</td>
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accompanied by sexual excitement

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Penis</td>
<td>The male sex organ</td>
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<tr>
<td>Prostate Gland</td>
<td>Lies under the bladder and surrounds the end of the urethra in the region where the vas deferens enters the urethra</td>
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<tr>
<td>Scrotum</td>
<td>The saclike structure that surrounds, protects, and supports the testicles</td>
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<tr>
<td>Seminal Vesicle</td>
<td>Glands that secrete a thick, yellow substance to nourish the sperm cells</td>
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<tr>
<td>Sperm</td>
<td>The male gametes (reproductive cells)</td>
</tr>
<tr>
<td>Testicles</td>
<td>The two small, egg-shaped glands that produce the sperm</td>
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<tr>
<td>Testosterone</td>
<td>A steroid hormone that stimulates development of male secondary sexual characteristics, produced mainly in the testes, but also in the ovaries and adrenal cortex</td>
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<tr>
<td>Uterus</td>
<td>A pear-shaped organ with muscular walls and a mucous membrane lining filled with a rich supply of blood vessels</td>
</tr>
<tr>
<td>Vagina</td>
<td>The muscular tube lined with mucosa that extends from the cervix to the outside of the body</td>
</tr>
<tr>
<td>Vulva</td>
<td>Consists of the labia, clitoris, Bartholin’s gands, and vaginal orifice</td>
</tr>
<tr>
<td>Zygote</td>
<td>The single cell formed that results from the union of sperm and egg; a new life</td>
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REFERENCES


APPENDIX B

LESSON PLANS FOR OT 426:
PERSONAL PROFESSIONAL DEVELOPMENT

The lesson plans may be incorporated into the existing course curricula with the discretion of the instructor. There are three learning activities included.

1. The Circles of Human Sexuality
   • Handout
   • An Explanation of the Circles of Sexuality
2. Introduction to Sexual Orientation
   • How it Feels to be Different: Exercise in Guided Imagery
3. Who Am I?
   • I Am
   • Social Group Membership Profile
The Circles of Human Sexuality

A Lesson Plan from Life Planning Education: A Youth Development Program

**Purpose:** To develop and understand a broad definition of sexuality

**Materials:** Newsprint and markers, board and chalk, one copy of the handout, Circles of Sexuality(pdf), for each participant, and the Leader's Resources, Circles of Sexuality (pdf), and An Explanation of the Circles of Sexuality; pens or pencils

**Time:** 45 minutes

**Planning Notes:** Review the Leader's Resource, Circles of Sexuality, and draw a large version of it on newsprint or the board.

**Procedure:**
Explain that when many people see the words "sex" or "sexuality," they most often think of sexual intercourse. Others also think of other kinds of physical sexual activities. Tell the group that sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who every person is. It includes all the feelings, thoughts, and behaviors of being female or male, being attracted and attractive to others, and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity.

Write sexuality on the board and draw a box around the letters s-e-x. Point out that s, e, and x are only three of the letters in the word sexuality.

Display the five circles of sexuality and give each teen a handout. Explain that this way of looking at human sexuality breaks it down into five different components: sensuality, intimacy, identity, behavior and reproduction, and sexualization. Everything related to human sexuality will fit in one of these circles.

Beginning with the circle labeled sensuality, explain each circle briefly. Take five minutes to read the definition of the circle aloud, point out its elements, and ask for examples of behaviors that would fit in the circle. Write the examples in the circle and ask participants to write them on their handouts. Continue with each circle until you have explained each component of sexuality.

Ask if anyone has any questions.

Then conclude the activity using the discussion questions below.

**Discussion Questions:**

- Which of the five sexuality circles feels most familiar? Least familiar? Why do you think that is so?
• Is there any part of these five circles that you never before thought of as sexual? Please explain.
• Why are all 5 circles important for OT’s and healthcare professionals to be aware of?
• Which circle(s) would you feel most comfortable discussing with your client(s)? Least comfortable?

Circles of Sexuality

SENSUALITY
Awareness, acceptance of and comfort with one's own body; physiological and psychological enjoyment of one's own body and the bodies of others.

SEXUALIZATION
The use of sexuality to influence, control or manipulate others.

INTIMACY
The ability and need to experience emotional closeness to another human being and have it returned.

SEXUAL HEALTH AND REPRODUCTION
Attitudes and behaviors related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behavior.

SEXUAL IDENTITY
The development of a sense of who one is sexually, including a sense of maleness and femaleness.
An Explanation of the Circles of Sexuality

A Lesson Plan from Life Planning Education: A Youth Development Program

Leader's Resource for the Circles of Sexuality Lesson Plan

Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she/he will become. It includes all the feelings, thoughts, and behaviors associated with being female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and sensual and sexual activity. It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing, and sight.

Circle #1—Sensuality

Sensuality is awareness and feeling about your own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give us and others. This part of our sexuality affects our behavior in several ways.

- Body image—Feeling attractive and proud of one's own body and the way it functions influences many aspects of life. Adolescents often choose media personalities as the standard for how they should look, so they are often disappointed by what they see in the mirror. They may be especially dissatisfied when the mainstream media does not portray or does not positively portray physical characteristics the teens see in the mirror, such as color of skin, type or hair, shape of eyes, height, or body shape.
- Experiencing pleasure—Sensuality allows a person to experience pleasure when certain parts of the body are touched. People also experience sensual pleasure from taste, touch, sight, hearing, and smell as part of being alive.
- Satisfying skin hunger—The need to be touched and held by others in loving, caring ways is often referred to as skin hunger. Adolescents typically receive considerably less touch from their parents than do younger children. Many teens satisfy their skin hunger through close physical contact with peers. Sexual intercourse may sometimes result from a teen's need to be held, rather than from sexual desire.
- Feeling physical attraction for another person—The center of sensuality and attraction to others is not in the genitals (despite all the jokes). The center of sensuality and attraction to others is in the brain, humans' most important "sex organ." The unexplained mechanism responsible for sexual attraction rests in the brain, not in the genitalia.
- Fantasy—The brain also gives people the capacity to have fantasies about sexual behaviors and experiences. Adolescents often need help understanding that sexual fantasy is normal and that one does not have to act upon sexual fantasies.
Circle #2—Sexual Intimacy
Sexual intimacy is the ability to be emotionally close to another human being and to accept closeness in return. Several aspects of intimacy include:

- Sharing—Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness.
- Caring—Caring about others means feeling their joy and their pain. It means being open to emotions that may not be comfortable or convenient. Nevertheless, an intimate relationship is possible only when we care.
- Liking or loving another person—Having emotional attachment or connection to others is a manifestation of intimacy.
- Emotional risk-taking—To have true intimacy with others, a person must open up and share feelings and personal information. Sharing personal thoughts and feelings with someone else is risky, because the other person may not feel the same way. But it is not possible to be really close with another person without being honest and open with her/him.
- Vulnerability—To have intimacy means that we share and care, like or love, and take emotional risks. That makes us vulnerable—the person with whom we share, about whom we care, and whom we like or love, has the power to hurt us emotionally. Intimacy requires vulnerability, on the part of each person in the relationship.

Circle #3—Sexual Identity
Sexual identity is a person's understanding of who she/he is sexually, including the sense of being male or of being female. Sexual identity consists of three "interlocking pieces" that, together, affect how each person sees him/herself. Each "piece" is important.

- Gender identity—Knowing whether one is male or female. Most young children determine their own gender identity by age two. Sometime, a person's biological gender is not the same as his/her gender identity—this is called being transgender.
- Gender role—Identifying actions and/or behaviors for each gender. Some things are determined by the way male and female bodies are built or function. For example, only women menstruate and only men produce sperm. Other gender roles are culturally determined. In the United States, it is considered appropriate for only women to wear dresses to work in the business world. In other cultures, men may wear skirt-like outfits everywhere.

There are many "rules" about what men and women can/should do that have nothing to do with the way their bodies are built or function. This aspect of sexuality is especially important for young adolescents to understand, since peer, parent, and cultural pressures to be "masculine" or "feminine" increase during the adolescent years. Both young men and young women need help sorting out how perceptions about gender roles affect whether they feel encouraged or discouraged in their choices about relationships, leisure activities, education, and career.
Gender bias means holding stereotyped opinions about people according to their gender. Gender bias might include believing that women are less intelligent or less capable than men, that men suffer from "testosterone poisoning," that men cannot raise children without the help of women, that women cannot be analytical, that men cannot be sensitive. Many times, people hold fast to these stereotyped opinions without giving rational thought to the subject of gender.

- Sexual orientation—Whether a person's primary attraction is to people of the other gender (heterosexuality) or to the same gender (homosexuality) or to both genders (bisexuality) defines his/her sexual orientation. Sexual orientation begins to emerge by adolescence although many gay and lesbian youth say they knew they felt same sex attraction by age 10 or 11. Between three and 10—percent of the general population is probably exclusively homosexual in orientation. Perhaps another 10 percent of the general population feel attracted to both genders.

Heterosexual, gay, lesbian, and bisexual youth can all experience same-gender sexual attraction and/or activity around puberty. Such behavior, including sexual play with same-gender peers, crushes on same-gender adults, or sexual fantasies about same-gender people are normal for pre-teens and young teens and are not necessarily related to sexual orientation.

Negative social messages and homophobia in the wider U.S. culture can mean that young adolescents who are experiencing sexual attraction to and romantic feelings for someone of their own gender need support so they can clarify their feelings and accept their sexuality.

**Circle #4—Reproduction and Sexual Health**
These are a person's capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy and enjoyable.

- Factual information about reproduction—Is necessary so youth will understand how male and female reproductive systems function and how conception and/or STD infection occur. Adolescents often have inadequate information about their own and/or their partner's body. Teens need this information so they can make informed decisions about sexual expression and protect their health. Youth need to understand anatomy and physiology because every adolescent needs the knowledge and understanding to help him/her appreciate the ways in which his/her body functions.
- Feelings and attitudes—Are wide-ranging when it comes to sexual expression and reproduction and to sexual health-related topics such as STD infection, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.
- Sexual intercourse—Is one of the most common behaviors among humans. Sexual intercourse is a behavior that may produce sexual pleasure that often culminates in orgasm in females and in males. Sexual intercourse may also result in pregnancy and/or STDs. In programs for youth, discussion of sexual intercourse is often limited to the bare mention of male-female (penile-vaginal)
intercourse. However, youth need accurate health information about sexual intercourse—vaginal, oral, and anal.

- Reproductive and sexual anatomy—The male and female body and the ways in which they actually function is a part of sexual health. Youth can learn to protect their reproductive and sexual health. This means that teens need information about all the effective methods of contraception currently available, how they work, where to obtain them, their effectiveness, and their side effects. This means that youth also need to know how to use latex condoms to prevent STD infection. Even if youth are not currently engaging in sexual intercourse, they probably will do so at some point in the future. They must know how to prevent pregnancy and/or disease.

Finally, youth also need to know that traditional methods of preventing pregnancy (that may be common in that particular community and/or culture) may be ineffective in preventing pregnancy and may, depending on the method, even increase susceptibility to STDs. The leader will need to determine what those traditional methods are, their effectiveness, and their side effects before he/she can discuss traditional methods of contraception in a culturally appropriate and informative way.

- Sexual reproduction—The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction—the process whereby two different individuals each contribute half of the genetic material to their child. The child is, therefore, not identical to either parent. [Asexual reproduction is a process whereby simple one-celled organisms reproduce by splitting, creating two separate one-celled organisms identical to the original [female] organism before it split.] Too many programs focus exclusively on sexual reproduction when providing sexuality education and ignore all the other aspects of human sexuality.

**Circle #5—Sexualization**

Sexualization is that aspect of sexuality in which people behave sexually to influence, manipulate, or control other people. Often called the "shadowy" side of human sexuality, sexualization spans behaviors that range from the relatively harmless to the sadistically violent, cruel, and criminal. These sexual behaviors include flirting, seduction, withholding sex from an intimate partner to punish her/him or to get something, sexual harassment, sexual abuse, and rape. Teens need to know that no one has the right to exploit them sexually and that they do not have the right to exploit anyone else sexually.

- Flirting—Is a relatively harmless sexualization behavior. Nevertheless, upon occasion it is an attempt to manipulate someone else, and it can cause the person manipulated to feel hurt, humiliation, and shame.
- Seduction—Is the act of enticing someone to engage in sexual activity. The act of seduction implies manipulation that at times may prove harmful for the one who is seduced.
- Sexual harassment—Is an illegal behavior. Sexual harassment means harassing someone else because of her/his gender. It could mean making personal, embarrassing remarks about someone's appearance, especially characteristics
associated with sexual maturity, such as the size of a woman's breasts or of a man's testicles and penis. It could mean unwanted touching, such as hugging a subordinate or patting someone's bottom. It could mean demands by a teacher, supervisor, or other person in authority for sexual intercourse in exchange for grades, promotion, hiring, raises, etc. All these behaviors are manipulative. The laws of the United States provide protection against sexual harassment. Youth should know that they have the right to file a complaint with appropriate authorities if they are sexually harassed and that others may complain of their behavior if they sexually harass someone else.

• Rape—Means coercing or forcing someone else to have genital contact with another. Sexual assault can include forced petting as well as forced sexual intercourse. Force, in the case of rape, can include use of overpowering strength, threats, and/or implied threats that arouse fear in the person raped. Youth need to know that rape is always illegal and always cruel. Youth should know that they are legally entitled to the protection of the criminal justice system if they are the victims of rape and that they may be prosecuted if they force anyone else to have genital contact with them for any reason. Refusing to accept no and forcing the other person to have sexual intercourse always means rape.

• Incest—Means forcing sexual contact on any minor who is related to the perpetrator by birth or marriage. Incest is always illegal and is extremely cruel because it betrays the trust that children and youth give to their families. Moreover, because the older person knows that incest is illegal and tries to hide the crime, he/she often blames the child/youth. The triple burden of forced sexual contact, betrayed trust, and self-blame makes incest particularly damaging to survivors of incest.


http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/200(task=view)
Introduction to Sexual Orientation
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

**Purpose:** To learn about issues faced by gay, lesbian, bisexual, and questioning people and to promote acceptance and respect for all people irrespective of their sexual orientation

**Materials:** Leader's Resource, Guided Imagery

**Time:** 45 minutes

**Planning Notes:** Sexual orientation is a controversial topic. This activity is designed to promote understanding, acceptance, and respect. While being sensitive to the community's attitudes, remember that young people need accurate information and an opportunity to discuss an issue that may be difficult for them. As you lead this activity, remember that there are probably gay, lesbian, bisexual, and questioning persons in your group. You will not know the sexual orientation of every participant, so be very sure to use inclusive and affirming language. For example, say 'we,' 'all people,' and 'some people,' not 'they' or 'people like them.'

**Procedure:**
Without revealing the topic of the activity, begin reading the Guided Imagery (Leader's Resource for this activity).

After you have finished the Guided Imagery, ask the participants to sit up, open their eyes if they were closed, and reconnect with the group. Ask each participant to turn to the person next to her/him and take a few minutes to talk about how it would feel to live in such a world and what it would feel like if they had to keep so many secrets about themselves. Then, ask the pairs to discuss what those feelings might lead them to do if this were a real situation.

Call the group back together and ask for volunteers who are willing to share their thoughts and feelings with the whole group. Write their responses on newsprint. Add checkmarks when other participants offer the same or similar responses. Expect to hear answers like: feeling angry, sad, and isolated; dropping out of school; staying home from school; using alcohol and other drugs; breaking the rules; and feeling depressed. If youth do not suggest these feelings and responses, suggest them yourself.

Explain that while the situation is, of course, fictional, it mirrors the real world faced by many lesbian, gay, bisexual, and questioning people. Say that, because they are often understandably afraid to 'come out' (reveal their sexual orientation) to others, gay, lesbian, and bisexual teens are forced to keep many parts of their lives secret. Sometimes keeping so many secrets leads to their dropping out of school, staying home from school, using alcohol and other drugs, running away, breaking the rules, etc. Say that, eventually, most gay, lesbian and bisexual people, including teens, find ways to tell the people who are important to them and find friends who are supportive of them. The struggle to decide
who is safe to tell lasts all of one's life, because there is so much ignorance and fear about homosexuality in our society.

End with the Discussion Questions below.

**Discussion Questions:**

- How would it feel to have to hide something as important and as basic as your sexual orientation, (the sex of the people to whom you are romantically, emotionally, and physically attracted)?
- What were the first things you remember learning about homosexuality?
- Do you remember learning anything from your family? Friends? Community of faith?
- Was what you learned positive or negative?
- Have you ever learned about or discussed issues of sexual orientation in class? What did you learn?
- What movie or television character have you recently seen that is GLBTQ? How has that affected your thinking?
- How would it feel to need to hide from other people your gender or the sex of those to whom you are attracted? How would that affect your life?


http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/237?task=view
How It Feels to Be Different: Exercise in Guided Imagery
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

Leader's Resource for Introduction to Sexual Orientation Lesson Plan

Slowly read the following to the participants.

Please get comfortable. If you feel comfortable to do so, close your eyes as you sit or lay back. Concentrate as I take you to a world very different from the one in which we live—a world in which you are straight, but everyone else is not. In this world, almost all of the teachers and students in your school are gay. All of your friends and family members are gay; most of the doctors, judges, politicians and world leaders are gay. Celebrities are all gay, as are all of the priests, rabbis, Sufis, and imams. In this world, all of the books and television programs are about gay characters, and marriage is legal only for gay couples. Of course, there are some straight people, but they are ridiculed and whispered about. Clearly, there is something really bad about being straight. You have heard things like: straight people are sick; they are obsessed with sex.

Programs on television sometimes explore the curious 'straight lifestyle,' describing how straight people are always getting pregnant or infected with HIV. In these programs, straights are like the characters out of an old circus sideshow—exposed for their oddities. Your friends have told you that straight people are often child abusers and you have overheard your neighbor saying that straights are emotionally disturbed and have no morals. Last year there was a big problem in your town because someone accused one of the teachers of being straight—parents don't want straight people to teach their children—so, the teacher was fired even though she insisted that she was gay. There are few, if any, protections for straight people. You have heard that straights can't lead scout troops, and that straights can be fired from their jobs or kicked out of the military if people find out about them. There's even a story you heard last week about a kid who was kicked out of his own home because he told his dad he might be straight.

This is all very scary for you because you are beginning to think that you, too, might be straight. More than anything in the world, you want your parents to love you, to accept you as you are. What will they say if you tell them that you might be straight?! The thought of telling them—of telling anyone—makes you sick to your stomach. Who can you turn to? Your brothers talk nonstop about how cute the quarterback on the local football team is. Your sister has a crush on the latest supermodel. You wish you had a crush on someone of your own sex, but you don't! It's people of the opposite sex that attract you. No one in your family has these feelings—in fact, no one you know has them, so you continue to hide this scariest of secrets. Somewhere deep inside you understand that, if people found out who you really are, they would ridicule you. Worse yet—they might not love you anymore!

Sometimes you think that you have to tell someone about this secret. You spend hours thinking about whom to approach. You remember when you were a kid hearing your dad tell nasty jokes about straights at the dinner table and everyone laughed. So, you can't tell your family. You remember your family's religious leader telling the congregation that being straight is unnatural and immoral and the whole congregation nodded in agreement. So telling the religious leader is definitely out. In health class you
learned that it is normal to feel physically and emotionally attracted to people of your same sex. No one talked about being attracted to someone of the opposite sex. You are sure that what you are feeling cannot be normal and that no one can help you. Last week in math class, two of the popular athletes started taunting this shy kid and calling him 'straight.' The teacher just ignored it. You heard her laugh the week before, however, when the kid in the second row called out in disgust that the poem the class was supposed to read for English was so straight. All of this makes you feel really isolated and afraid. You are unsure what to do. Where can you turn? Who can you talk to? You can't talk about your feelings at home; your school feels unsafe; you don't trust your friends to support you. Having this secret is a little like having a piranha inside—it keeps eating away at your self-esteem, so that after a while you hate how you feel and you hate yourself, too!

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http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/238?task=view
Who Am I?
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

**Purpose:** To get participants thinking about their own identities and how discrimination and privilege affect their life

**Time:** 40 minutes

**Materials:** Handouts, *I Am* and *Social Group Membership Profile*

**Procedure:**
Begin by saying, "Everyone is a member of different social groups—groups of people who have something in common. Sometimes that can be something like the school you go to or the kind of TV shows you like. We all belong to larger social groups as well—groups that involve our gender identity, race/ethnicity, socio-economic status, abilities, religion, age, sexual orientation, etc. It's important when we are thinking about how to treat others that we think about where we belong in terms of social groups."

Say that you will now pass out a sheet of paper that will help participants think about their social groups. Distribute the *I Am* handout. Briefly describe the different groups to which each person belongs. Ask participants to take a few minutes to write down, or if they don't feel comfortable, to think about where they are in terms of their social groups.

With the entire group, spend a few minutes sharing how it felt to identify in these groups. Ask if participants spend much time thinking about the groups they are a part of. Say that one thing about social groups is that, sometimes, we don't realize what benefits or barriers go with our membership in some of these groups, especially membership in a group that is dominant in society. Distribute the *Social Group Membership Profile* handout. Go over the instructions at the top of the sheet. Ask participants to spend five minutes individually answering the questions on the handout.

Ask participants to break up into groups of three to discuss their own sheets. Remember that some people may not feel comfortable revealing certain aspects of their social groups. Explain that each person can be as general or as specific as they would like in the discussion and also that everyone has the right to pass on discussing any point. Conclude with the Discussion Questions in the entire group.

**Discussion Questions:**
- What surprised you about this exercise? Why?
- What benefits did you see that you enjoy just because you belong to some groups?
- What problems or barriers did you see that you face just because you belong to some groups?
- What benefits did you see that others enjoy and you do not because of the groups that they belong to?
- What barriers did you see that others face and you do not because of the groups that they belong to? How do you feel about that?
• Should things be more equal and fair?
• What can you do to make things more equal and fair for everyone?
**I Am**  
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

Handout for Who Am I? Lesson Plan

I Am!

<table>
<thead>
<tr>
<th>My Gender Is</th>
<th>My Religion Is</th>
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<tbody>
<tr>
<td>_________________________</td>
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<table>
<thead>
<tr>
<th>My Race/Ethnicity Is</th>
<th>My Talents Include</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>___________________________</td>
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<table>
<thead>
<tr>
<th>My Economic Background Is</th>
<th>My Interests Include</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>___________________________</td>
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<table>
<thead>
<tr>
<th>My Age Is</th>
<th>My Sexual Orientation Is</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

**Other Social Groups to Which I Belong Include**

____________________________________

These are the social groups to which I belong!

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Social Group Membership Profile
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

Handout for Who Am I? Lesson Plan
Use your answers on the I Am handout to respond to the questions below.

Of all of the social groups to which you belong:

Which ones are you most comfortable with?

Which are you least comfortable with?

Which do you think most about?

Which do you think least about?

Which groups give you the most privileges?

Which groups limit your access, options, and/or rewards in society?

Which have the greatest effect, positively or negatively, on how others see you?

http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/230?task=view
REFERENCES


APPENDIX C

LESSON PLANS FOR OT 430:
PSYCHOSOCIAL ASPECTS OF OT WITH CHILDREN, ADOLESCENTS, AND YOUNG ADULTS

The lesson plans may be incorporated in to the existing course curricula with the discretion of the instructor. There are three learning activities included. Three supplementary articles are included as resources for additional information on varying topics appropriate for class facilitation.

1. Identity Formation Lesson Plan
2. Case Example: Karen
3. Safari of Life and Young Man’s Journey Card Sets

Additional Resources:

1. Sex Education for Physically, Emotionally, and Mentally Challenged Youth
2. Positive Youth Development as a Strategy to Promote Adolescent Sexual and Reproductive Health
3. Sexual Violence
Identity Formation Lesson Plan

Title: Identity Formation
Key Words: psychosocial development, identity, identity confusion (role confusion)
Time Allotted: 55 Minutes
Authors: Danielle Bates and Gus Teller (2004)

Purpose/Rationale:
This lesson is designed to introduce students to identity formation and how different aspects of an individual’s life can contribute to this formation. Identity formation is a critical moment in human development. Although identity formation begins in early adolescence, many individuals can go into adulthood struggling to discover who they are. While there are many differing theories on identity formation, most researchers would agree that outside factors or influence help to determine how one’s identity is formed. It is important for students to not only understand how identity is formed but how their surrounding environment has influenced this formation.

Key Concepts:
1. Identity vs. Identity confusion (role confusion) – This is the fifth stage (crisis) of Erik Erikson’s psychosocial development. During this crisis, adolescents seek to develop a coherent sense of self, which includes their societal role.
2. Psychosocial Development (in Erikson’s theory) – The socially and culturally influenced process of development of the self. This occurs in eight stages, which occur across the lifespan. As the crisis in each stage arises, individuals must find a healthy balance between the alternative positive and negative traits.

<table>
<thead>
<tr>
<th>Essential Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Erik Erikson’s theory on identity formation</td>
</tr>
<tr>
<td>- Theory based on a series of stages and crisis.</td>
</tr>
<tr>
<td>- Identity formation is the fifth stage of Erikson’s theory (Identity vs. Role Confusion)</td>
</tr>
<tr>
<td>- Stage occurs in adolescence and can continue into adulthood.</td>
</tr>
<tr>
<td>2. Formation of identity</td>
</tr>
<tr>
<td>- How adolescents form identity.</td>
</tr>
<tr>
<td>- 3 major issues in identity formation</td>
</tr>
<tr>
<td>3. Outside influences of identity formation</td>
</tr>
<tr>
<td>- Gender differences.</td>
</tr>
<tr>
<td>- Ethnic Factors.</td>
</tr>
<tr>
<td>- Sexual Orientation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Essential Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Analyze the effects of life events on identity formation.</td>
</tr>
<tr>
<td>2. Analyze personal identity and how it was formed.</td>
</tr>
</tbody>
</table>
Guiding Question(s):
What is identity and how is it formed? What influences an individual to become who they are?

Assessment Tool(s):
Formal – Worksheet
Informal – Classroom Discussion

Background
Students will have had previous experience with Erik Erikson and his theories of human psychosocial development. Students will have previous knowledge of Erikson’s first four stages of development, with an understanding of what a crisis is and how it is resolved in each of the four stages. Student should have just finished covering the common characteristics of adolescence, both physical and cognitive.

Lesson Objective(s)
Students will be able to:
1. Identify the fifth stage of Erik Erikson’s stages of psychosocial development.
2. Describe the possible underlying factors on identity formation and their potential to greatly influence individuals.

Additional Materials/Resources:
1. Worksheet for ‘Just Do It’ and continuation activity.
2. Note cards with potential influencing factors of identity formation.

Procedure/Process
Just Do It:
Time Allotment: 5 Minutes
1. On the screen will be the first slide of a PowerPoint presentation (See Materials Section, Material A). Students will be asked to immediately get started on the ‘Just Do It’ as soon as the teacher hands out the worksheet that students must complete.
2. Teacher says, “I am handing you a worksheet to complete for the ‘Just Do It’ for today. Please complete ONLY column A of the worksheet. Once you are finished, please turn the worksheet over.”
3. Directions state: Please complete only Part 1 of the worksheet. (See Materials Section, Material B).

Objective # 1
Activity: Lecture through Power Point Presentation
Time Allotment: 10 Minutes
Directions:
1. Show Slide 2 of the Power Point Presentation (See Materials Section, Material C).
2. Briefly go over the objectives for today’s class.
3. Teacher begins lecture by asking what the students remember about Erikson’s stages of psychosocial development.
4. Use slides 3-5 (See Materials Section, Material C) to review Erikson’s theory of
psychosocial development and how identity formation fits into this theory.

5. Students will be given slot notes (See Materials Section, Material D) to fill out throughout the class period based on the PowerPoint Presentation. The word or words to fill into the notes directly corresponds to the underlined words in the slide show presentation.

6. Thoughts and ideas to be presented:
   - This is only one theory, out of many, on identity formation.
   - We look at Erikson’s theory because it was one of the first theories on identity formation.
   - Define psychosocial development according to Erikson’s theory.
   - Explain the 5th stage of Erikson’s theory: Identity vs. Identity Confusion (Role Confusion).

Assessment: Informal – Attentiveness of students.

Transition: “Please take out the worksheet you used to complete the ‘Just Do It’ for today.”

Objective #2
Activity: Influencing Factors (Note cards and Worksheet)
Time Allotment: 7 Minutes
Directions:
1. Teacher will hand out note cards to each student. Each note card will have a factor written on it that could potentially influence identity formation. A list of all the factors given to students can be found in the Materials Section under Material E.
2. Students will be asked to think about what is written on their note card as if the event occurred during the early stages of adolescence and complete Part 2 of their worksheet.
3. Teacher says, “Take a look at the event on your note card. Think about when you were an early adolescent and the effect this event would have had on your life during that time period. Factor in the event and answer the questions in Part 2 of your worksheet.”
4. After students have completed their worksheet, have students share what their note cards say to each other.
5. Students will be asked to discuss how their identity changed from Part 1 to Part 2 with the other students sitting around them.

Assessment: Formal – Worksheet

Transition: “Now that you have completed your worksheet and discussed what happened with each other, let’s talk about the differences between parts A and B as a class.”

Objective #2
Activity: Discussion
Time Allotment: 15 Minutes
Directions:
1. Students should come together as a class to discuss the note card activity and their
worksheets. Students should begin to compare and contrast the influences of events in parts 1 and 2 and how the impact of a new life event in part 2 changed their opinions on their identity.

2. Some questions to ask:
   - Teacher says, “Look back at your ‘Just Do It’ and tell me what types of events influenced you the most?” The teacher will write these events on the board.
   - When you look at part 2 of your worksheet, do you believe the events on your note card would influence identity formation? What are they? And how would they influence it?
   - Looking at the list of events we have come up with on the board, do these events look like minor or major events?
   - What aspect of your life do these events relate to? Are there a variety of situations that you see?

Do you believe that outside forces effect identity formation? Why would this be the case?

**Objective #: 2-3**
**Time Allotment:** 15 Minutes
**Activity:** Lecture through PowerPoint

**Directions:**
1. Use slides 7-11 of the PowerPoint Presentation to show students how identity was formed according to Erik Erikson.
2. Students will continue to fill in slot notes as the lecture continues.
3. Thoughts and ideas to be presented:
   - Identity is formed through synthesis of old and new ideas on identity and who we believe we should be as individuals.
   - Erikson believes that in order to form our identity we must resolve three major areas in our lives: occupation, values and sexual orientation.
   - Successful resolution of the identity crisis is fidelity.
   - Gender, ethnicity and sexual orientation play vital roles in identity formation.
   - Potential problems with Erikson’s theory.

**Closure/Writing Prompt:** In closing, students will be asked to complete the following writing assignment which appears on slide 12 of the Power Point Presentation (See Materials Section, Material C). Students must begin the assignment in class and if they do not finish it, they must complete the writing assignment for homework. The directions state: *Thinking about the activity and discussion we have had in class today... write a paragraph or two describing how much you believe life events influence identity formation.*
Materials Section

Material A:
PowerPoint Slide 1

“Just Do It”

- Please complete only PART 1 of the worksheet.
- While completing the worksheet think about who you believe you are as a person and how you came to feel this way about yourself.
**Material B:**

**PART 1**

*Just Do It and Influencing Factors Worksheet*

Answer the following questions based on who you are today:

1. How would you describe yourself?

2. How do your friends, family and teachers describe you?

3. How would strangers describe you in passing (at a first glance)? What judgments would they make about you?

4. What aspect of your life has influenced you the most?

**PART 2**

Answer the following questions based on the note card you received:

1. How would you describe yourself now?

2. How would your friends, family and teachers describe you?

3. How would strangers describe you in passing (at a first glance)? What judgments would they make about you?

4. What aspect of your life has influenced you the most?
Material C:  
PowerPoint Presentation (Slides 2-12)  

Objectives  
Today we will be covering the following:  
1). Erikson’s theory of psychosocial development as it relates to identity formation.  
2). Erikson’s three factors that influence identity formation.  
3). The major issue surrounding Erikson’s theory of identity formation.  
4). Your own thoughts on identity formation.  

Erikson’s Theory of Psychosocial Development (Review)  
- Erikson’s theory consists of 8 stages. Within each stage a crisis must be resolved. This crisis is a major developmental issue that becomes important during a specific time period throughout one’s life.  
- In order to be successful at solving this crisis, one must balance positive and a corresponding negative trait.
Erikson’s Theory of Psychosocial Development Continued...

- In most situations the positive traits prevail. However, Erikson did believe that negative traits are needed as well.
- Example: In infancy, the crisis is trust vs. mistrust. People need to learn to trust the world around them but in order to do this, they also need to learn about mistrust to protect themselves from danger.

Erikson’s theory on identity formation...

- Stage 5 of Erikson’s theory is identity formation, which begins in adolescence. The crisis in this stage is known as identity vs. identity confusion which is also known as role confusion.
- During this stage adolescents are attempting to make sense of who they are and what their valued role is in society.
Note Card Activity

Take a look at your note card and the factor it states on it.

- Think about the factor on your note card.
- Answer the questions in Part 2 of your worksheet.
- When you finish, begin thinking about how your thoughts were changed from
- Part 1 to Part 2.

Erikson’s Theory on Identity Formation Continued...

- Identity is NOT formed by mimicking others. It is formed by taking early assumptions about identity, modifying and synthesizing those ideas into a new structure.
- The resolution of three main areas is key to resolving conflicts in identity formation. They are choice of occupation, the adoption of values to live by and believe in and the development of a satisfying sexual identity.
Erikson’s Theory of Identity Formation
Continued...

- When the crisis in stage 5 is successfully resolved, it is known as fidelity. When this occurs, individuals have developed a sustained loyalty, faith, or a sense of belonging to a loved one or to friends. It can also mean identification with a certain set of values, religious group, political group, etc.

Factors that Influence Identity Formation...

- There are multiple factors that can influence identity formation. The first factor is gender since males and females form their identity through different ways. Women form their identity through relationships while men do not. This usually occurs since women tend to have lower self esteem than men.
Factors that Influence Identity Formation Continued...

- The next factor is ethnicity. Identity formation is extremely complicated for members of a minority group. Physical features can greatly influence an individual’s self concept.
- The final factor is sexual orientation. Society makes it difficult for individuals with a sexual orientation that differs from the heterosexual norm. Stereotypes and discrimination are huge factors here.

Potential Problem with Erikson’s Theory on Identity Formation...

- Erikson considered male identity formation to be the norm. He stated that women formed their identity through intimacy while men could not be involved in
- Intimacy until after their identity had been fully formed. This is why many disregard Erikson’s theory as the truth and simply use it to build upon.
Writing Assignment

Complete the following writing assignment.

• Thinking about the activity and discussion we have had in class today... write a paragraph or two describing how much you believe life events influence identity formation.
Erik Erikson and Identity Formation

Review: Erik Erikson’s Theory of Psychosocial Development.

Erikson’s theory consists of __________. Within each stage a ______ must be resolved. This crisis is a major ______ issue that becomes important during a ______ time period throughout one’s life. In order to be successful at solving this crisis, one must balance __________ and a corresponding ________ trait. In most situations the ________ traits prevail. However, Erikson did believe that ________ traits are needed as well.

Example: In infancy, the crisis is ____________. People need to learn to trust the world around them but in order to do this; they also need to learn about ________ to ________ themselves from danger. ______________ of Erikson’s theory is identity formation, which begins in _____________. The crisis in this stage is known as __________ vs. ____________, which is also known as _______________. During this stage adolescents are attempting to __________ of ___________ and what their ____________ is in society.

Erikson’s Theory on Identity Formation

Identity is ______ formed by mimicking others. It is formed by taking ___________ about identity, ___________ and ___________ those ideas into a _________ structure.

The __________ of three main areas is key to resolving conflicts in identity formation. They are choice of ____________, the adoption of ___________ to live by and believe in and the development of a satisfying ____________. When the crisis in stage 5 is successfully resolved, it is known as ___________. When this occurs, individuals have developed a ____________ loyalty, faith, or a sense of belonging to a loved one or to friends. It can also mean ____________ with a certain set of values, religious group, political group, etc.
Factors that Can Influence Identity Formation

There are multiple factors that can influence identity formation. The first factor is ________ since males and females form their identity through ________ ways. ________ form their identity through ________ while men do not. This usually occurs since women tend to have ________ self esteem than men. The next factor is ________. Identity formation is extremely ________ for members of a minority group. ________ can greatly influence an individual’s ________. The final factor is ________. ________ makes it difficult for individuals with a sexual orientation that differs from the ________. ________ and ________ are huge factors here.

Problems Associated with Erikson’s Theory

Erikson considered ________ identify formation to be the ________. He stated that ________ formed their identity through ________ while ________ could not be involved in intimacy until ________ their identity had been fully formed. This is why many ________ Erikson’s theory as the truth and simply use it to ________.
Material E:
Note cards

Potential Influencing Factors List:

**Males:**
You have just recovered from cancer treatment. You are bald from hair loss, but you are healthy.
You have just recently come out to your family and friends as being a homosexual male.
You are still in the closet about being a homosexual male.
Your grandmother has just passed away.
You are deaf.
You are a Muslim, pre September 11th.
You have a learning disability that causes you to read slower than your classmates. You have been confined to a wheelchair since birth.
You are a natural baseball talent. Scouts are already starting to talk to you about your potential future in the majors.
You have just received a national academic award for excellence.

**Females:**
You have just recovered from a car accident in which you lost one of your arms.
You have just had your heart broken by your boyfriend. You two were together for a year.
You are blind.
You walk with a limp and have since childhood.
You have just been recognized as having the best grade point average in your class. You have extremely low self esteem.
You have a ton of friends.
You only have one friend.
You are a Muslim, post September 11th.
Teacher’s Notes/Explanations/Reflections:

1. Remember to make copies of both worksheets.
2. Remember to make note cards. Separate them by gender.
3. Keep a copy of the detailed worksheet on identity formation as a reference sheet just in case you need it.
## Case Example: Karen

### Presenting Problem
Karen, a 17-year-old Korean American girl, has been referred by a local free clinic which offers testing for STDs. She has been sexually acting out and apparently abusing alcohol and drugs.

### Interpersonal Difficulties
Karen tells the clinician that alcohol and drugs help her forget the intrusive nightmares she has been having. These started when she and her boyfriend became sexually intimate. She and her boyfriend have also been getting into fights. She states that almost every time he tries to get close to her, she becomes agitated and lashes out at him. “It’s different when we go to parties, though. When he brings some Ecstasy for us, I can have a good time.”

### Relevant History and Context
During a home visit, the clinician discovers that Karen and her parents have also been experiencing stress and economic hardship. As first-generation immigrants, the parents work long hours and rely on their children to help them with household chores. “All she does is lie around and watch TV! We can’t make her do anything! She causes us so much trouble,” they complain. The clinician learns that when Karen was little, a Korean neighbor babysat the girl. The parents found out that the woman’s husband had repeatedly abused their daughter. This was distressing for them because it went on for about three years and they felt bad about not being around when Karen was younger. This also caused more hardship for them because they had to find a new babysitter. “But that was a long time ago,” they state. They also express concern about her current acting out behaviors: “We wish Karen would be more careful and respect the rules more.”

### Discussion Points
- **What screening and assessment instruments might be helpful at this juncture to learn more about the causes of Karen’s emotional turmoil?**
- **What kind of information must you obtain to discern between mental health and substance abuse/dependence problems?**
- **What has been the likely impact of Karen’s earlier trauma exposure on her current behavior and functioning?**
- **In your treatment plan, which issue would you address first: Karen’s traumatic stress symptoms, her substance abuse, her risky behaviors, or the needs within the family?**
- **Briefly describe how you would employ specific therapy skills to help Karen overcome her difficulties. (e.g., cognitive restructuring, problem solving, assertiveness training, exposure to the trauma narrative, etc.)**
Safari of Life and Young Man’s Journey Card Sets

This section includes four card sets, designed to be photocopied and cut out for use within various game structures, including Not-So- Trivial pursuit, or a game of your own devising. Originally created for the PATH board games Safari of Life and A Young Man’s Journey, they may be adapted for use with a homemade or existing game board from another game. Players can race around the board, earning points or extra turns for correct and/or thoughtful answers. Some data in these cards may become outdated or may contain information that is not appropriate for your youth or location. Key issues for your youth may also need more coverage through additional cards developed by your program. Please review the content carefully before play.

Safari of Life Card Sets
These cards present a general overview of sexuality, reproductive health and social issues. They are appropriate for any age, based on an easy to intermediate level of comfort or knowledge

- **Facts Cards** - These cards address basic sexuality issues through close-ended questions. The answers are printed on the cards. Another player should read the card aloud to the player or team who have chosen the card.
- **Feelings Cards** - There are no “right or wrong” answers to these open-ended questions designed to generate discussion about sexuality and general issues. These work best with facilitation that encourages respect and thoughtful answers. Other players may want to add their perspectives as well.

A Young Man’s Journey Card Sets
In response to feedback from older teen players from around the world, these cards are more difficult than the Safari of Life cards. They cover a wide range of health and sexuality issues, with a focus on male physiology, gender relations, violence, and homophobia. They have been well received by both male and female players worldwide. The USA-specific cards can be amended to reflect data from other countries, as needed.

- **Quickpoints Cards** - As with the Facts Cards, these specific questions have the answers printed directly on the cards, and should be read aloud to the team or player who have chosen the card.
- **Opinions Cards** - As with the Feelings Cards, there are no "right or wrong" answers to these cards. Quality facilitation of the discussions can add substantially to their value.
**Fact Cards**

<table>
<thead>
<tr>
<th>NAME two sexually transmitted infections (STI).</th>
<th>TRUE or FALSE? If you have unprotected sexual intercourse with someone who has a sexually transmitted infection, you probably won’t catch it.</th>
<th>WHAT are two ways to protect oneself against sexually transmitted infections?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer: HIV/AIDS, gonorrhea, syphilis, Chlamydia, herpes, hepatitis B, genital warts, pubic lice (“crabs”)</td>
<td>FALSE. You may well catch it.</td>
<td>Answer: No sexual intercourse (abstinence). Condoms also protect against most STIs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRUE or FALSE? IF a pregnant woman has a sexually transmitted infection, her unborn child can be harmed by it.</th>
<th>Name two symptoms of sexually transmitted infections for females.</th>
<th>TRUE or FALSE? Most sexually transmitted infections (except HIV/AIDS) can be treated and usually cured by a doctor or clinic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE. But a medical visit can catch and cure most STIs, even during pregnancy.</td>
<td>Answer: Pain during sex, unusual discharge, burning while peeing, intense pelvic pain...although females often have STIs and no symptoms at all.</td>
<td>TRUE.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRUE or FALSE: If a guy has trouble peeing, or his penis burns, or white stuff like pus comes out of his penis, this is normal and there's no need to worry.</th>
<th>TRUE or FALSE? You can get HIV/AIDS from toilet seats, mosquitoes, dirty dishes or hugging someone with HIV/AIDS.</th>
<th>TRUE or FALSE? A person can have a sexually transmitted infection, including HIV (which causes AIDS), and not even know it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALSE. All of these are symptoms of sexually transmitted infections (STIs) and he should visit a doctor or clinic immediately.</td>
<td>FALSE. You CANNOT catch HIV/AIDS these ways.</td>
<td>TRUE. Especially for females.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME 2 ways of becoming infected with HIV, the virus that causes AIDS.</th>
<th>TRUE or FALSE? In many places, reliable, simple HIV testing is available.</th>
<th>TRUE or FALSE? Having sexual intercourse always feels great.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer: Having sexual intercourse/oral sex with an infected person—sharing drug needles—blood transfusion with infected blood (rare)—pregnant or nursing mother to her baby (but special drugs can make this unlikely).</td>
<td>TRUE.</td>
<td>FALSE. Sometimes it’s not good if you are emotionally upset, have never had intercourse, are still learning about sexuality, are just not in the mood—or are forced (raped).</td>
</tr>
<tr>
<td>TRUE or FALSE?</td>
<td>TRUE or FALSE?</td>
<td>TRUE or FALSE?</td>
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<td>--------------------------------</td>
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<td>-----------------------------------------</td>
</tr>
<tr>
<td>Having an orgasm (sexual climax) is always the best part of sexual acts.</td>
<td>Sexual intercourse is the best and only way to be sexually satisfied.</td>
<td>Once someone has sexual intercourse, they know everything about sex.</td>
</tr>
<tr>
<td>FALSE. Sometimes the emotional rewards are best. Sometimes orgasm isn’t reached BUT the partners still physically enjoy themselves.</td>
<td>FALSE. Choices include kissing, masturbation of oneself or partner, rubbing clothed bodies together, and many others.</td>
<td>FALSE. Sexual intercourse and sexuality are much more complicated than that. There is a lifetime of learning ahead.</td>
</tr>
<tr>
<td>TRUE or FALSE?</td>
<td>TRUE or FALSE?</td>
<td>NAME three methods of birth control (contraception).</td>
</tr>
<tr>
<td>Sexual partners often feel too shy to tell each other what feels good physically and emotionally.</td>
<td>Contraception (birth control) is what a couple uses to prevent pregnancy.</td>
<td>Abstinence (no intercourse)—male &amp; female condom—birth control pills— injection—IUD (interuterine device)—implants—contraceptive foam, jelly, and inserts—diaphragm—cervical cap—withdrawal—natural family planning—sterilization—emergency contraception</td>
</tr>
<tr>
<td>TRUE. But a relationship is stronger when partners do learn to talk about their sexual relationship.</td>
<td>TRUE. Some birth control methods also protect against sexually transmitted infection.</td>
<td></td>
</tr>
<tr>
<td>TRUE or FALSE?</td>
<td>What is “dual method use?” Why do people use it?</td>
<td>TRUE or FALSE?</td>
</tr>
<tr>
<td>If the birth control method a couple uses fails, or they forget to use a method, it is too late to prevent pregnancy.</td>
<td>This means using two contraceptive methods at once—to get maximum protection from both pregnancy AND sexually transmitted infections. Examples include condoms AND pills, or condoms AND injection...</td>
<td>Just because you have reached puberty, that means you are ready for sexual intercourse.</td>
</tr>
<tr>
<td>FALSE. They have 72 hours (3 days) to use Emergency Contraception, but the sooner taken, the less chance of pregnancy.</td>
<td>FALSE. Sexual intercourse is best for emotionally ready people who know how to respect each other, and protect against pregnancy, infection and related issues.</td>
<td></td>
</tr>
<tr>
<td>TRUE or FALSE?</td>
<td>TRUE or FALSE?</td>
<td>TRUE or FALSE?</td>
</tr>
<tr>
<td>Boys usually experience puberty (body changes as one becomes an adult) before girls.</td>
<td>Most young people’s bodies grow at the same speed and look very similar.</td>
<td>Sexual intercourse can result in pregnancy.</td>
</tr>
<tr>
<td>FALSE. Girls usually begin puberty BEFORE boys. (Girls usually reach puberty between ages 9-16, and boys from 11-17)</td>
<td>FALSE. Everyone’s body and growth timeline is different. (You’re one of a kind!)</td>
<td>TRUE.</td>
</tr>
</tbody>
</table>
**TRUE or FALSE?**
When a man ejaculates inside a woman during intercourse, 200 million sperm are released, but only 15 sperm are needed to get the woman pregnant.

**Answer:** FALSE. Only ONE sperm is needed!

<table>
<thead>
<tr>
<th>TRUE or FALSE?</th>
<th>NAME three signs of pregnancy.</th>
<th>TRUE or FALSE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW MANY MONTHS does an average pregnancy last?</td>
<td>Answer: No menstrual period, breast tenderness and/or enlargement, weight gain, expanding abdomen, nausea, tiredness.</td>
<td>A pregnancy test from the pharmacy is not very reliable.</td>
</tr>
<tr>
<td><strong>Answer:</strong> Nine months.</td>
<td><strong>FALSE.</strong> Once a woman’s period is late, it is a very good way to find out if she is pregnant. Then a check-up at a doctor or clinic can confirm it’s a normal pregnancy.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRUE or FALSE?</th>
<th>HOW MANY DAYS is the average woman’s menstrual cycle (from 1st day of period to 1st day of next period)?</th>
<th>TRUE or FALSE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The younger a woman is, the easier for her to get pregnant—and the more likely to have irregular menstrual cycles (so it’s harder for her to know when she is fertile).</td>
<td>Answer: 28 days (about a month), but for some women it’s as short as 25 days, some longer than 32 days, or not regular.</td>
<td>A female’s menstrual period usually lasts for about 2 days.</td>
</tr>
<tr>
<td><strong>Answer:</strong> TRUE.</td>
<td><strong>FALSE.</strong> Average length is 4 days, but can run from 3 to 7 days.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRUE or FALSE?</th>
<th>AT WHAT TIME during a woman’s menstrual cycle can she become pregnant?</th>
<th>CAN YOU DESCRIBE three body changes that occur for girls during puberty?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A girl can begin her period as early as nine years old.</td>
<td>Answer: When she is OVULATING, which is typically 14 days before the first day of the NEXT menstrual period (but not always!)</td>
<td>This passageway in a woman’s body has three main roles: menstrual fluid passes through it, as does a baby being born. It is also the place a man’s penis is inserted during sexual intercourse. What is it called?</td>
</tr>
<tr>
<td><strong>Answer:</strong> TRUE.</td>
<td><strong>Answer:</strong> Growth spurt, breast growth, rounding of hips, hair growth (underarm and pubic), menstruation, increasingly sensitive clitoris.</td>
<td><strong>Answer:</strong> OVARY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FILL IN THE MISSING WORD...</th>
<th>FILL IN THE MISSING WORD...</th>
<th>FILL IN THE MISSING WORD...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eggs are stored, and mature in the woman’s ____________.</td>
<td>This passageway in a woman’s body has three main roles: menstrual fluid passes through it, as does a baby being born. It is also the place a man’s penis is inserted during sexual intercourse. What is it called?</td>
<td>The egg from the ovary travels through a canal called the ________ tube, on the way to the uterus.</td>
</tr>
<tr>
<td><strong>Answer:</strong> OVARY</td>
<td><strong>Answer:</strong> VAGINA</td>
<td><strong>Answer:</strong> FALLOPIAN</td>
</tr>
<tr>
<td>Fill in the Missing Word...</td>
<td>Fill in the Missing Word...</td>
<td>Fill in the Missing Word...</td>
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</tr>
<tr>
<td>A woman’s genitals or “private parts” are called the ________.</td>
<td>Every month or so, one egg gets ripe and leaves a woman’s ovary, ready to be fertilized. This process is called ________.</td>
<td>Why should women examine their breast and vulvas regularly? Why should men examine their testicles?</td>
</tr>
<tr>
<td>Answer: VULVA</td>
<td>Answer: OVULATION</td>
<td>Answer: In case there are ever any changes that will be symptoms of illness or tumors.</td>
</tr>
<tr>
<td>Can you describe three body changes that occur for boys during puberty?</td>
<td>TRUE or FALSE? During puberty, some boy’s breasts grow a little bit and become sore, only to disappear later.</td>
<td>In the USA, what percentage of males are circumcised? (foreskin cut off penis, usually as a baby)</td>
</tr>
<tr>
<td>Answer: Growth spurt, voice change, muscle growth, hair growth (underarm, pubic, face, chest), genital growth &amp; erections, sperm production, ejaculation (including “wet dreams”).</td>
<td>TRUE.</td>
<td>Answer: About 50%</td>
</tr>
<tr>
<td>Fill in the Missing Word...</td>
<td>Fill in the Missing Word...</td>
<td>Fill in the Missing Word...</td>
</tr>
<tr>
<td>The penis is made of spongy tissue. When special passages in this tissue fill up with blood, the penis becomes hard and stands out from the body. This is called an ____________.</td>
<td>Sperm are produced in a man’s ________.</td>
<td>The thick pouch of skin that holds a male’s testicles is called the ________.</td>
</tr>
<tr>
<td>Answer: ERECTION</td>
<td>Answer: TESTES</td>
<td>Answer: SCROTUM</td>
</tr>
<tr>
<td>What is the release of semen (fluid containing sperm) from the penis called?</td>
<td>TRUE or FALSE? Boys usually experience their first ejaculation between the ages of 19 and 20.</td>
<td>What is a &quot;wet dream&quot;?</td>
</tr>
<tr>
<td>Answer: EJACULATION.</td>
<td>FALSE. Boys usually first ejaculate between ages 11 and 15.</td>
<td>Answer: A harmless, common, physical happening for boys; an ejaculation (release of semen from the penis) during sleep.</td>
</tr>
<tr>
<td>Fill in the Missing Word...</td>
<td>What are 3 things a woman should, or should not do, during pregnancy, to keep herself and her baby healthy?</td>
<td>Fill in the Missing Word...</td>
</tr>
<tr>
<td>When a baby is about to be born, the mother’s uterus muscles start to tighten and loosen and push the baby toward the vagina to be born. At this point, the woman is in ________.</td>
<td>Good nutrition—gentle, regular exercise—plenty of rest—no smoking, drugs or alcohol—visit health clinic regularly.</td>
<td>When a pregnancy ends before 9 months, and the lifeless fetus passes from the body naturally, this is commonly called a ________.</td>
</tr>
<tr>
<td>Answer: LABOR</td>
<td></td>
<td>Answer: MISCARRIAGE</td>
</tr>
</tbody>
</table>
FILL IN THE MISSING WORD...
When a woman ends her pregnancy by medical means, this is commonly called an _______.
Answer: ABORTION.

NAME one "eating disorder" and describe it.
ANOrexia—dangerously starving oneself, and obsessing about weight.
BuLeMia—binge eating and causing oneself to vomit, while obsessing about weight.

TRUE or FALSE?
Most rapes are committed by someone the victim knows.
TRUE. But no matter who commits the crime of rape, it is still very wrong.

NAME one "eating disorder" and describe it.
ANOREXIA—dangerously starving oneself, and obsessing about weight.
BULEMIA—binge eating and causing oneself to vomit, while obsessing about weight.

TRUE or FALSE?
Most rapes are committed by someone the victim knows.
TRUE. But no matter who commits the crime of rape, it is still very wrong.

WHAT IS sexual intercourse?
Answer: When a male and female put his penis inside her vagina.

TRUE or FALSE?
Breastfeeding babies (instead of feeding formula) makes them healthier, helps the mother lose pregnancy weight faster, and is much cheaper than formula.
TRUE.

TRUE or FALSE?
Shouting, name calling and threats can be a serious form of abuse.
TRUE. Because mental health is as important as physical health.

Feeling Cards

<table>
<thead>
<tr>
<th>How do you show your favorite people that you love them?</th>
<th>What is your reaction to people drinking alcohol and smoking cigarettes?</th>
<th>Describe the ideal parent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Homophobia” means fear and hatred towards homosexuals and lesbians. What are your thoughts about homophobic people and the things they say?</td>
<td>If you see a classmate being cruel to someone else, what do you do?</td>
<td>How do you know the difference between right and wrong?</td>
</tr>
<tr>
<td>What are some reasons that people have abortions? What are your thoughts about those reasons?</td>
<td>Some people think a person’s skin color doesn’t matter much. Others believe it does matter. What do you think?</td>
<td>What chores do you do at home? Are they “masculine” or “feminine” chores? What makes them so? Do you agree?</td>
</tr>
<tr>
<td>In the last movie you saw, what messages about sexuality were in it? What are your reactions to the messages?</td>
<td>What is your favorite song right now? What messages about sexuality are in it? What are your reactions to the messages?</td>
<td>How do you feel about the shape of your body?</td>
</tr>
<tr>
<td>Why do some people agree to have sex when they don't want to? Are the reasons the same for males and females?</td>
<td>What is your reaction to the statement: “If you love me, you will have sexual intercourse with me.”</td>
<td>What is your reaction to this common explanation for unplanned pregnancy: “Then things just happened...”</td>
</tr>
<tr>
<td>What are three reasons that people say “No” in a sexual situation, even though they want to continue?</td>
<td>What are three possible connections between unsafe or unplanned sex AND alcohol and drugs?</td>
<td>What is your reaction to someone who pressures their partner to have sex, when the partner doesn’t want to? What should the partner do?</td>
</tr>
<tr>
<td>Question</td>
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<td>Question</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>What are three reasons teenagers have sex?</td>
<td>What do you think about teenagers having babies?</td>
<td>What are three reasons adults have sex?</td>
</tr>
<tr>
<td>What are two problems a person might have if he/she becomes a parent while in school?</td>
<td>Imagine going to the pharmacy or clinic for condoms. How would you feel? Why?</td>
<td>Name two things that keep young people from discussing sex with their parents or teachers.</td>
</tr>
<tr>
<td>People with low self-esteem (lots of self doubts) sometimes end up with an unplanned pregnancy or STI. What could be some connections between self-esteem and sexuality?</td>
<td>What sexual topics do people you know talk about? What do they say?</td>
<td>Name three ways to be physically close without sexual intercourse.</td>
</tr>
<tr>
<td>How do you think your parents feel about you growing up? Why?</td>
<td>Name two things that would make it easier for clients to talk with a healthcare provider about sexual issues.</td>
<td>What does the word “sexuality” mean to you? What parts of your life are connected to your sexuality?</td>
</tr>
<tr>
<td>What do you think is the best thing about being a parent?</td>
<td>Name something you want the adults in your life to say to you, or about you, more often. Why? Which adults?</td>
<td>What do you think is the most difficult thing about being a parent?</td>
</tr>
<tr>
<td>When I am my parents’ age, I expect to be...</td>
<td>How do you show respect to adults, and how do you want them to show respect to you?</td>
<td>Name something you want the adults in your life to say to you, or about you, less often. Why? Which adults?</td>
</tr>
<tr>
<td>What sexual issues should parents or adults discuss with young people? Why?</td>
<td>Why would a parent be concerned about their child’s sex life? What is the best way to talk to their child about it?</td>
<td>How do parents try and control their children? Why do they do it? When is it fair?</td>
</tr>
<tr>
<td>In Guinea, Africa, they say, “Knowledge is like a garden. If it’s not cultivated, it cannot be harvested.” How might this relate to sexuality?</td>
<td>In Nigeria, Africa, they say, “Not to know is bad, but not to wish to know is worse.” How might this relate to sexuality?</td>
<td>Some young people say, “I have the right to do what I want with my body.” Some adults say, “You are too young to have intercourse and should wait.” What do you think?</td>
</tr>
<tr>
<td>In Congo, Africa, they say, “The toad that wanted to avoid the rain fell in the water.” How might this relate to sexuality?</td>
<td>In Africa, they say, “There is no better mirror than a best friend.” What does this say about you?</td>
<td>In Liberia, Africa, they say, “Only when a tree is grown can you tie your cow to it.” How might this relate to sexuality?</td>
</tr>
<tr>
<td>Name a belief or myth you have heard about sex like, “If you have sex standing up, you won’t get pregnant.” Do you believe it? Why or why not?</td>
<td>Think of someone who has had a positive influence on your health behavior. What does that person do or say that supports you?</td>
<td>In Tanzania, Africa they say, “I pointed out the stars to you and all you saw was the tip of my finger.” How might this relate to sexuality?</td>
</tr>
</tbody>
</table>
### Quick Point Cards

**QUESTION:** When is an abusive (violent) man more likely to hit a woman: when things are going well in his life, or when they are not going well?

Experts think that a man is more likely to abuse a woman when he feels bad about himself, because he feels like he has no power in his life, and hitting someone makes him feel powerful. Sadly, that is a hopeless and hateful way to try to feel powerful.

**TRUE or FALSE?** An important way to protect health is by discussing contraception and sexually transmitted infection prevention before ever having intercourse.

TRUE. When people decide to take the risks that come with intercourse, they should be mature enough to be responsible. Otherwise, they should wait.

**QUESTION:** What does it mean when a male is circumcised?

Circumcision is the surgical cutting away of the foreskin, the fold of skin at the front end of the penis. Often done soon after birth, for religious reasons, or as a tradition. Uncircumcised and circumcised boys and men should wash their penis and testicles regularly. Circumcision makes no difference in how the penis works.

**TRUE or FALSE?** In the US, if a young man fathers a child, the child is as much his responsibility as the mother’s.

TRUE. US society supports the belief that a father should offer love and care to his children, and the law demands that he financially support his child or children too.

**TRUE or FALSE?** Mental health experts believe the love of a mother is the only love a child really needs.

FALSE. While children DO want their mommies, they also want love and care from fathers too, and brothers, sisters, grandparents and friends.

**Which statement is true?**

1. Rapes most commonly happen in poorly lighted public places, at night.
2. Most rapes are committed by someone the victim knows.
3. Elderly people are in the greatest danger of rape since they can’t fight off attackers as well.

**TRUE or FALSE?** In the US, as well as many countries worldwide, it is against the law for a husband to force his own wife to have sex.

TRUE. Rape is a crime in the US, even by a husband against his wife. (Men can also be raped, which is also illegal.)

**QUESTION:** What does “contraceptive” mean?

A “contraceptive” is any type of birth control, which are ways of not becoming pregnant after a man and woman have vaginal intercourse.

**TRUE or FALSE?** In the US, it is against the law for a husband to force his own wife to have sex.

TRUE. Rape is a crime in the US, even by a husband against his wife. (Men can also be raped, which is also illegal.)

**QUESTION:** When is an abusive (violent) man more likely to hit a woman: when things are going well in his life, or when they are not going well?
**TRUE or FALSE?**
One unrolls a condom before putting it on the penis.

**FALSE.** It should be unrolled over the penis. (The unrolled condom should be placed over the tip of the erect penis, leaving a half inch of space to collect semen. Next, the condom is unrolled to the base of the penis. The latex ring should be on the outside. The condom should fit snugly.)

**QUESTION:** Males can be victims of rape at any time in their lives. However, which time of life is most common for males to suffer from rape or sexual abuse?

**ANSWER:** As children or teens, many males are sexually abused or raped. The best way to recover from this potentially damaging crime is to talk with a counselor or doctor who is an expert on the topic.

**QUESTION:** About what percent of American teens remain abstinent until age 17 or older? (Abstinence means no intercourse.)

**ANSWER:** Over 50 percent. (Over half of all teens have not had intercourse by age 17.)

**Name two possible causes of impotence (penis that can’t get hard)?**

1. Injury (particularly to the pelvic area)
2. Stress
3. Alcohol
4. Depression
5. Diabetes
6. High blood pressure (medication for)
7. High cholesterol
8. Smoking
9. Drugs (and some medicines)

**MULTIPLE CHOICE.** Breastmilk is known as “nature’s perfect food.” Which animal produces breastmilk that has more fat than butter?

A. Elephant seal  
B. Human  
C. Elephant  
D. Platypus

**ANSWER:** A. In one month, the elephant seal pup grows from a birth weight of 75 pounds to 300 pounds. During this time, the mother loses six hundred pounds. Breastfeeding also speeds human mother’s loss of pregnancy weight gain.

**TRUE or FALSE?** Often with the help of treatment, both male and female victims of childhood sexual abuse can have satisfying, healthy lives.

**TRUE.** In many countries there are organizations helping sexual abuse victims, like RAINN in the USA (1-800-656-HOPE), and doctors and clinics (like Planned Parenthood) can help.

**TRUE or FALSE?** In the USA, a father should help pay the costs of raising his child every month for 18 years. But if he chooses not to, that’s his right.

**FALSE.** The US law says a father must financially support his children. If he doesn’t, he can have his pay taken from him or even get arrested.

**QUESTION:** How can a man make a woman infertile (meaning that she is not able to become pregnant)?

**ANSWER:** By giving her a sexually transmitted disease, many of which can lead to infertility if not treated. (Also, coercing her to be sterilized.)

**TRUE or FALSE?** In many countries, a person can be sent to jail for threatening violence.

**FALSE.** In some countries, threatening violence can lead to arrest, but in others, it is not considered a human rights abuse.

**MULTIPLE CHOICE.** Which of the following statements is false?

1. Hateful teasing can be damaging & dangerous.  
2. In many countries, a person can be sent to jail for threatening violence.  
3. If no physical injury follows a threat, it is not considered a human rights abuse.  
4. “Stalking” is a type of serious threat.

**ANSWER:** C is false—serious threats are human rights abuses.
<table>
<thead>
<tr>
<th>TRUE or FALSE?</th>
<th>QUESTION: If a woman says “No” to sexual advances, what choices does her partner have?</th>
<th>TRUE or FALSE? If a woman is wearing sexy clothes in an unsafe environment, she is “asking for it.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some condoms can be used more than once.</td>
<td>TRUE. Male condoms cannot be reused, but some types of female condoms can be reused if properly cleaned.</td>
<td>FALSE. NO ONE “asks” to be raped. Rape is a crime committed by the rapist.</td>
</tr>
</tbody>
</table>

**QUESTION:** Which of the following are true side effects of masturbation: insanity; slower penis growth; low sperm count; pimples/acne, interrupted sleep cycle?  
None — masturbation has no bad physical effects. Some people believe it is mentally healthier than suppressing sexual impulses.

**SPELLING BACKWARDS**  
Without writing it down, one player must spell the following word backwards, aloud:  
C O N T R A C E P T I O N

**TRUE or FALSE?** At some point in their lives, most people have sexual feelings, thoughts, and attractions to someone of the same sex.  
TRUE. It is normal to have these feelings, even if you are heterosexual. However, some people remain attracted only to people of the same sex (homosexual) and some are attracted to both sexes (bisexual).

**SPELLING BACKWARDS**  
Without writing it down, one player must spell the following word backwards, aloud:  
T E S T I C L E

**TRUE or FALSE?** Contraceptive pills make it impossible to get pregnant later in life.  
FALSE. It is possible for a woman to get pregnant even within a few days of stopping them.

**QUESTION: At what ages does a boy’s penis start to grow significantly?**  
ANSWER: Significant penis growth typically doesn’t start until around 11–16 years of age (average: 13–14).

**NAME ONE OF THE TOP THREE CAUSES OF DEATH OF YOUNG MEN WORLDWIDE.**  
Top three causes of young men’s death, in order:  
1. Road traffic accidents (sometimes due to showing off, drugs, alcohol)  
2. Injuries (including work-related)  

**QUESTION: Does a man need to ejaculate every time he has an erection?**  
ANSWER: No — if he just waits, the erection will go down on its own without causing any harm.

**QUESTION: Is it common for both males and females to masturbate?**  
ANSWER: Yes, masturbation is very normal and is practiced by most people. It is also normal not to masturbate.
**TRUE or FALSE?**
If you are a 15-year old boy or girl in some parts of Africa today, statistics show you have about an 80% chance of dying of AIDS within ten years.

TRUE. This tragic fact shows how urgent the problems of HIV and AIDS are in our world.

**TRUE or FALSE?**
One to two percent of males occasionally wake up with a hard penis.

FALSE. This is quite common for many males, not just one to two percent.

**QUESTION:** Name three things a woman should do for a healthy pregnancy.

ANSWERS: Good nutrition; no alcohol, drugs or smoking; plenty of rest; health care throughout pregnancy; safe, regular exercise

**TRUE or FALSE.**
An erect penis shouldn’t be curved.

FALSE. Some men’s erect penises are curved slightly. This is normal.

**QUESTION:** What is the “normal” size of a non-erect penis?

Normal penis size covers a wide range, and the average size is probably smaller than you think: about 3 inches (about 9 cm) in a non-erect, mature male.

**TRUE or FALSE.**
The Surgeon General of the United States reports that many scientists have concluded that gays and lesbians seem to be naturally born as homosexuals, and it is unlikely anything can change that fact.

TRUE. If you have internet access, go to surgeon-general.gov for more information.

**QUESTION:** What does “dual protection” mean?

It means using a condom at the same time as another contraceptive (like “the pill”) to protect against both disease AND pregnancy. Abstinence also has the benefits of dual protection.

**QUESTION:** When should a boy stop himself from having wet dreams?

ANSWER: Never, since it is not possible to control. They are normal and natural; almost all adolescent boys have them.

**QUESTION:** What is premature ejaculation?

ANSWER: This common event means the male gets so stimulated that he ejaculates (comes) before intercourse. With experience, a man can learn to avoid it.

**QUESTION:** What is the shortest time a woman should allow between births to protect her own and her babies’ health?

ANSWER: Two years between births is the minimum spacing, and 3 years gives the newborn and the older child the best odds to get healthy starts in life.
**TRUE or FALSE?**

**Having sex with a female virgin will cure a male of AIDS.**

FALSE. Currently, AIDS is not curable, and is only treatable with medication. All having sex with a virgin will do is to expose her to the risk of HIV the first time she ever has sex.

---

**QUESTION: What do we mean by HIV and what do we mean by AIDS?**

**ANSWER:** HIV stands for Human Immunodeficiency Virus, and AIDS (Acquired Immuno Deficiency Syndrome) is the disease caused by this virus.

---

**QUESTION: Can you have the AIDS virus (HIV) and still test negative?**

**ANSWER:** Yes, especially if you were infected within the last few weeks.

---

**Name at least three things you can do to stay healthy longer if you are HIV-positive.**

Follow doctor's instructions; keep all medical appointments; take medications on schedule; eat healthy foods; get enough sleep and rest; exercise regularly; don’t smoke; keep your spirits healthy; stay hopeful.

---

**QUESTION: What is the most sensitive part of a woman’s body? Where is it located?**

**ANSWER:** The clitoris is located on the vulva, in front of the vaginal opening. It has 8,000 nerve fibers, twice the amount found in the penis. This is the highest concentration of nerves found anywhere on the body.

---

**QUESTION: Do girls/women usually prefer to have sexual intercourse with someone with a big penis?**

**ANSWER:** No, not always. In fact some females find that a penis that is too big can cause discomfort when it touches her cervix, located at the back of her vagina.

---

**QUESTION: Can a person spread a sexually transmitted infection and not know it?**

**ANSWER:** Yes, because the person may not have any symptoms or signs of the illness, or may not understand the symptoms.

---

**FILL IN THE MISSING WORD:**

**In addition to blood, you can catch the HIV/AIDS virus through semen, vaginal fluids, and ______.**

**ANSWER:** Breastmilk

---

**Name the only two contraceptive methods that prevent pregnancy and protect against sexually transmitted infections and HIV.**

**ANSWERS:** The male condom and the female condom.

---

**QUESTION: Can a sexually transmitted infection cause a man to be infertile?**

**ANSWER:** Yes, if an STI is not treated.
### MULTIPLE CHOICE: Every year, how many sexually active American teens contract a sexually transmitted infection?

A. 1 in 100 teens  
B. 1 in 10 teens  
C. 1 out of every 4 sexually active teens gets an STI. Factors that affect your personal risk of infections include: being sexually active; high number of sexual partners; and consistency using condoms (just one act of unprotected sex can give you an STI!).

### TRUE or FALSE? Sexually transmitted infections can be spread through oral sex. (Oral sex is contact between mouth and sexual organs.)

**TRUE.**

### TRUE OR FALSE? A positive result from an “HIV test” means that a person has AIDS.

FALSE. If reconfirmed by another HIV test, it means a person is HIV positive. (If the test is negative, a person is either HIV negative or very recently infected.) AIDS is the disease that can result from HIV infection, sometime not appearing until ten years or more after HIV infection.

### Opinion Cards

**Can you think of a rule of “acceptable” behavior that is different for boys and girls? Is the difference fair to girls? To boys?**

**Research shows that when a romantic relationship becomes serious, the couple often thinks it is no longer necessary to use a condom. What do you think?**

**Describe something good you remember your Mom or Dad doing for you when you were a child.**

**What age difference between romantic partners do you think is too much? Why?**

**What are three of your favorite things to do on a weekend?**

**Which of your family members do you admire most? Why?**

**Some say an angry person should confront who is making them angry. Others think it’s best to cool off first. Describe a recent time when you were angry, and how you handled it.**

**Imagine overhearing people talking about you. What would you like them to be saying?**

**How well do you think your parents listen to you? How well do you listen to them? Give a recent example.**

**What are some ways you calm down when you are angry?**

**FINISH THIS SENTENCE with the first answer that pops into your head:**

“**The most important part of a romantic relationship is...”**

**FINISH THIS SENTENCE with the first answer that pops into your head:**

“**The thing I find most confusing about the opposite sex is...”**

**Adults often discuss the effects of peer pressure on youth. Do you think adults are affected by peer pressure? Give an example**

**FINISH THIS SENTENCE with the first answer that pops into your head:**

“**The person I admire most right now is...” Explain your answer.**

**If you saw some boys pulling a struggling girl into an empty room or other lonely place, what might be happening? Should you do anything?**

**Experts who study rape say that it is a kind of violence, not about needing sex. They think its main purpose is to hurt the victim and make the rapist feel powerful. What do you think?**

**What is date rape?**

**Is it ever all right to hit, beat or physically hurt someone?**
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Question</th>
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<tbody>
<tr>
<td>Is it ever OK for a woman to beat her husband or boyfriend? Is it ever OK for a man to beat his wife or girlfriend?</td>
<td>Often, people use the word “vagina” when they are really talking the &quot;vulva.&quot; (The vagina is the passage. The vulva includes vagina, clitoris, urethra (for urine), vaginal lips, and pubic hair.) Why do you think people don’t use the correct word?</td>
<td>What is sexual harassment? Why do people do it?</td>
</tr>
<tr>
<td>What do you think about parents spanking or beating their children?</td>
<td>Describe a man you know who treats the women in his life well (wife, girlfriend, friends). Who is he? How does he act?</td>
<td>What are some hateful names men call women? What bad names do women call men? Which ones are the worst?</td>
</tr>
<tr>
<td>Some people think the real reason men make bad comments about women is to impress other men. Do you think so? Why or why not?</td>
<td>If you had a son, would you have him circumcised? Why or why not?</td>
<td>What do you think of an HIV-positive person having unprotected (without a condom) sexual intercourse?</td>
</tr>
<tr>
<td>Describe a time when you felt proud of yourself.</td>
<td>What are some ways growing up in our society hurts or endangers boys and young men?</td>
<td>If a young person gets in trouble with the law, does that make him or her a criminal? What does it mean to be a criminal?</td>
</tr>
<tr>
<td>How old will you be in ten years? Describe the life you want to have by then and steps you’ll need to take to get what you want.</td>
<td>In some cultures, young women’s genitals are cut and altered—the clitoris may be cut off, and sometimes the vaginal lips are permanently sewed together. What are your thoughts on this practice?</td>
<td>What are different ways people have sexual intercourse?</td>
</tr>
<tr>
<td>Would a girl gain or lose a boyfriend’s respect if she asked him to use a condom? What if she had one in her pocket or purse?</td>
<td>Some people say that sexual intercourse is so amazing because it is both able to create life and to destroy life. Describe how that can be true.</td>
<td>A TRUE STORY: Doug is a kind, funny, handsome, lively, gay (homosexual) high school student. He accepted invitations to many proms from girls who are not gay, but know that he is. Do this seem odd to you, or not? Why?</td>
</tr>
<tr>
<td>Boys and men are often the victims of violence. Do you know males who have been hurt by violence? Have you ever been afraid of violence?</td>
<td>If two people have any type of sexual activity, what is the best way to protect themselves from sexually transmitted infections and HIV/AIDS?</td>
<td>If someone is being pressured to have sex, what are some ways he or she can let their partner know if they are not ready?</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If a teen couple you knew accidentally got pregnant, what would probably happen next?</td>
<td>If his girlfriend takes birth control pills, should a young man help pay for it?</td>
<td>Finish this sentence with the first answer that pops into your head: “The main reason adults and young people don’t talk much about sexuality issues is...” Explain your answer.</td>
</tr>
<tr>
<td>Do you want to have children someday? If so, when, how many and why?</td>
<td>Whose responsibility is it to prevent unwanted pregnancy? Do parents of teens have any responsibility for preventing pregnancy of their children?</td>
<td>What do you think about a girl who carries condoms?</td>
</tr>
<tr>
<td>What do people mean when they talk about a person’s sexual “reputation”? What would be a good reputation, or a bad one? For boys? For girls?</td>
<td>Finish this sentence with the first answer that pops into your head: “The best way to let someone know you are romantically interested in them is...” Explain your answer.</td>
<td>Do you think it is harder for men or women to talk openly about their fears and problems? Give an example.</td>
</tr>
<tr>
<td>Have you or someone you know ever experienced being gossiped/talked about unkindly? Give an example and describe how that felt.</td>
<td>How late do you think parents should let their 14-year-old son stay out? What about a 14-year-old daughter?</td>
<td>Every year teens kill themselves because they think they’re gay and fear the way that they will be treated. How do you treat someone who is gay?</td>
</tr>
<tr>
<td>In the US, a man was beaten to death for being gay (homosexual). In another case a woman was killed for being a lesbian. Why would people kill someone for being gay?</td>
<td>Can you think of at least five slang words that people use for penis? Where do these terms come from, and why?</td>
<td>In some parts of the US gay or lesbian couples can adopt children legally. Do you think a gay or lesbian couple can provide a good home for a child? Why or why not? What makes a good home?</td>
</tr>
<tr>
<td>Why do you think many men seem angry about gay men, even those they have never met? Do they feel the same about lesbian women?</td>
<td>Do you think a father should change his baby’s diapers (nappies) on a regular basis? Why or why not? What about feeding his baby or comforting it when crying?</td>
<td>Can you think of at least five words or phrases that people use instead of using the term “sexual intercourse?” Why do you think people come up with and use all these words?</td>
</tr>
<tr>
<td>Often gays and lesbians don’t even admit to themselves that they are attracted to their own gender. What, at first, are the dangers of this? On the other hand, what are the dangers of admitting homosexual feelings?</td>
<td>Some interviews have found that sometimes teen women and girls just want to cuddle, and not always have hugs and kisses lead to intense sexual activity or intercourse. Do you think many teens feel like this? How about males?</td>
<td>Do you think it is important for parents to know their children’s friends? Why? What should parents do if they don’t like one of their children’s friends?</td>
</tr>
</tbody>
</table>

Adapted with permission from Program for Appropriate Technology in Health (PATH), 2002
www.path.org
Sex Education for Physically, Emotionally, and Mentally Challenged Youth

Introduction

In recent years, important changes in public policies and attitudes have resulted in improved opportunities for people with physical and mental disabilities. Now, people living with disabilities assume their rightful place in society as the equals of non-disabled people. Unfortunately, societal attitudes have changed less in regard to sexuality and disability. Even today, many people refuse to acknowledge that all people have sexual feelings, needs, and desires, regardless of their physical and/or mental abilities. As a result, many young people who live with disabilities do not receive sex education, either in school or at home.

This summary addresses sex education for youth who live with physical and/or mental disabilities—including, but not limited to hearing, sight, and motor function impairments; Down syndrome; cerebral palsy; paraplegia and quadriplegia; developmental disorders; and mental health issues. Beginning with a few statistics on disability among American youth and an overview of common myths and facts about the sexuality of people living with disabilities, the document also provides general guidelines for parents of physically or mentally challenged children and youth and offers a select, annotated bibliography of sex education materials and resources.*

Are Disabilities Common among Children and Youth?

- According to the U.S. Census Bureau, about 5.2 million American youth, ages five through 20 had some long-term physical, mental, or emotional disabling condition.¹
- In the United States, nearly one million youth, ages three through 17 are deaf or hard of hearing.²
- Each year, about 5,000 infants and toddlers and up to 1,500 preschoolers are diagnosed with cerebral palsy. Experts also estimate that two of every 1,000 infants born in this country has cerebral palsy.³
- In the United States, nearly 94,000 school age children are blind. Of these, nearly 11,000 are both deaf and blind.⁴
- According to experts, about 7,800 Americans suffer spinal cord injuries each year—most (82 percent) occur among males and most frequently at age 19.⁵

Myths and Facts about Sexuality and Disability

Many people believe myths about the sexuality of people who live with disabilities. Common myths:

- People with disabilities do not feel the desire to have sex.
- People with developmental and physical abilities are child-like and dependent.
- People with disabilities are oversexed and unable to control their sexual urges.⁶

Myth 1: People with disabilities are not sexual. All people—including young people—are sexual beings, regardless of whether or not they live with physical, mental, or emotional disabilities. And, all people need affection, love and intimacy, acceptance, and companionship.⁶⁷ At the same time, children

* Advocates for Youth reminds readers that each young person is unique and may require a specialized program or resources—that is, each adolescent living with a disability is also an individual with individual reactions and needs regarding sex education. Thus, this document offers general guidance and should be used with care. It may or may not offer adequate resources to meet the particular needs of an individual.
and youth who live with disabilities may have some unique needs related to sex education. For example, children with developmental disabilities may learn at a slower rate than do their non-disabled peers; yet their physical maturation usually occurs at the same rate. As a result of normal physical maturation and slowed emotional and cognitive development, they may need sex education that builds skills for appropriate language and behavior in public. In another example, paraplegic youth may need reassurance that they can have satisfying sexual relationships and practical guidance on how to do so.6,7,8,9

Myth 2: People with disabilities are childlike and dependent. This idea may arise from a belief that a disabled person is somehow unable to participate equally in an intimate relationship. Societal discomfort—both with sexuality and also with the sexuality of people who live with disabilities—may mean that it is easier to view anyone who lives with disabilities as an ‘eternal child.’ This demeaning view ignores the need to acknowledge the young person’s sexuality and also denies her/his full humanity.6,7,8,9

Myth 3: People with disabilities cannot control their sexuality. This myth spins off the other two—if people with disabilities are neither asexual nor child-like, then perhaps they are ‘oversexed’ and have ‘uncontrollable urges’. Belief in this myth can result in a reluctance to provide sex education for youth with disabilities. The reality is that education and training are key to promoting healthy and mutually respectful behavior, regardless of the young person’s abilities.6,7,8,9

Why Should Parents Be Concerned about Sex Education for Their Disabled Children?

Parents are, or should be, their children’s primary sex educators, but many parents are afraid to talk to their children (disabled or not) about sex. Parents often fear that: 1) talking about sex will encourage sexual experimentation; 2) they (the parents) don’t know enough to handle questions appropriately; and 3) their children already know too much or too little. In addition, parents of children who are living with disabilities may feel that their children are potential targets for sexual abuse or exploitation. Or the parents may fear that their children may be unable to appropriately express their sexual feelings.

In short, parents often fear that talking about sex may cause problems. But, parents need to assist any child—regardless of her/his abilities—to develop life skills. For example, without appropriate social skills, young people may have difficulty making and keeping friends and feel lonely and ‘different’. Without important sexual health knowledge, young people may make unwise decisions and/or take sexual health risks.

General Guidelines for Parents

1. To begin with, acknowledge that everyone, including your child, is sexual—and has sexuality related emotions and desires.
2. Before you start a conversation with your child, make sure you know your own values and beliefs. Be honest with yourself.
3. Be ready to assert your personal privacy boundaries. For example, say forthrightly, if asked, that you will not discuss your own private sexual behavior.
4. Start talking with your children about sexuality while they are very young. Do not wait until they reach puberty (or later) for these conversations!
5. Use accurate language for body parts and bodily functions. Research shows that when a child has accurate language for private body parts, she/he is more likely to report abuse, if it occurs, than when the child lacks appropriate language.8
6. Identify times to talk and communication strategies that work best for you and your child. For example, the best time might be Saturday morning on the way to a sports event or after school while you share a snack. Your best strategy might be to play word games. For someone else, other times and strategies might work best.
7. Avoid times and strategies that do not work well for your children and your situation. For example, you may be unable to carry on a coherent conversation while driving. Or word games may confuse your child.
8. Be clear when discussing relationships. For example, calling your spouse ‘Mommy’ or ‘Daddy’ can confuse a child and send confusing messages about family relationships and about sexuality; instead explain the relationship. “Your Mommy is my wife, so I call her Sarah, not Mommy.” Or you might say, “Your Uncle Leroy is my brother, like Jason is your brother. Leroy is your uncle, because he is my brother. When you have kids, Jason will be their uncle.”
9. Use photos, pictures, and other visual materials as often as possible. Showing family photos may help your child to understand different types of families and relationships.
10. Use ‘teachable moments’ that arise in daily life. For example, talk about a neighbor’s new pregnancy or a friend’s upcoming marriage, divorce, move, operation, or retirement.

11. Be honest when your child asks questions. If you don’t know the answer, say so. Say you will find the answer and then do so. Be sure to get back to your child with the answer to her/his question.

12. Always acknowledge and value your child’s feelings and experience. Offer praise and support. Remember that minimizing how he/she feels is not a good way to build trust when talking about sensitive subjects. For example, “That’s a good question, and it is one I have had in the past, too.” Or, “I’m glad you feel happy when we talk. I feel happy, too.”

13. Be willing to repeat information over time. Don’t be impatient or expect your child to remember everything you said or to have entirely understood it.

14. Use all the reliable sources of information available to you—other parents whom you trust, the public library, reliable Web sites, local bookstores, educators, and health care providers. Information may be particularly useful to you when it comes from reputable organizations that deal with disabilities and/or sexuality. Be wary of relying on material that is negative about sexuality as such materials can limit your ability to be your child’s primary sex educator.

**General Guidelines for Professional Sex Educators**

Sex education materials and programs do exist that are designed to meet the needs of youth who live with physical, emotional, and/or mental disabilities. Whether these young people go to public or special school, live at home or in an institution, they need appropriate sex education and creative teaching methods. Although these general guidelines will be helpful, content and teaching methods must be particularized to meet the individual’s need.

1. Remember that, regardless of the physical, mental, or emotional challenges they face, young people have feelings, sexual desire, and a need for intimacy and closeness. In order to behave in a sexually responsible manner, each needs skills, knowledge, and support.

2. Understand that youth with disabilities are far more vulnerable to sexual abuse than are their peers. Youth who live with developmental disabilities are especially vulnerable. Sex education must, therefore, encompass skills to prevent sex abuse and encouragement to report and seek treatment for unwanted sexual activity.

3. Remember that youth who confront disabilities feel the same discomfort and suffer the same lack of information that hampers many of their peers regarding sexuality and sexual health.

4. Learn as much as you can about the disabilities of the populations with whom you work.

5. Be sure that the material addresses boundaries and limits—both setting boundaries and respecting others’ boundaries. Rely on role plays and interactive exercises. Use concrete teaching strategies.

6. Be creative. Develop specialized teaching tools and resources for the youth with whom you work. For example, in working with youth who have developmental disabilities, you may need to use visuals like models, dolls and pictures. For youth with physical disabilities, it may be useful to use stories and examples of others with similar disabilities who have loving, satisfying intimate relationships.

**References**

SELECTED RESOURCES FOR EDUCATORS AND OTHER YOUTH-SERVING PROFESSIONALS

Books

Reproductive Issues for Persons with Physical Disabilities—edited by F Hastline, PhD, MD, SS Cole, PhD, and DB Gray, PhD; Paul H. Brooks Publishing
Featuring contributions from disabled consumers and health professionals, this book dispels myths about sexuality and disability and explores sexual issues that challenge people with disabilities. It provides information on reproductive rights, sexual dysfunction, sexually transmitted infections, reproductive physiology, sexual development, health care needs, fertility, birth control, adoptions, pregnancy, labor and delivery, and parenthood and also personal stories of people with disabilities.

Sexuality and Disability—by M Blackburn; Butterworth-Heinemann Publisher
This book examines the physical and psychological aspects of disability and sexuality and boosts professional understanding of those with disabled patients, especially in regard to self-esteem, legal matters, abuse, adolescence, genetics and continence.

Enabling Romance: A Guide to Love, Sex, and Relationships for People with Disabilities (And the People Who Care about Them)—by K Kroll and EL Klein; No Limits Communications
This book is particularly recommended for its attention to the sex education needs of youth with all types of disabilities. Its three main components include disabilities and sexual satisfaction; life and love with specific disabilities; and resource information for independent living, dating services, and publications. It offers a wealth of information on relationships and reproductive issues.

This collection provides understanding of issues related to sexuality, intimacy, and disability. Articles address mental retardation and sexual expression; responding to the sexual concerns of persons with disabilities; holistic approaches to providing sex education and counseling for severely disabled people; and sexual assault.

This guide outlines a training program for professionals who work with people with developmental disabilities. It includes: understanding the sexuality of people with disabilities that hinder learning; attitudes about sexuality; personal exploration; sexuality counseling; sexual abuse and informed consent; working with parents and families; and programs and evaluations.

Curricula

Child Sexual Abuse Curriculum for the Developmentally Disabled—by SR Rappaport, PhD, SA Burkhardt, PhD, and AF Rotatori, PhD; Charles C. Thomas Publishers, 1997
This curriculum addresses child sexual abuse and the developmentally disabled; treatment of sexually abused children; and emotional and behavioral outcomes of sexual abuse. It includes 10 lessons on sexuality and sexual abuse prevention for children who are mildly retarded.

Human Sexuality: A Portfolio for Persons with Developmental Disabilities—by I Peters and J McKoy; Planned Parenthood of Western Washington
The portfolio contains large (11 x 17 inch) colored illustration plate cards for teaching developmentally disabled youth about human sexuality, including male and female bodies, male and female genitals, intercourse, and body shapes. The portfolio offers teaching techniques and ideas along with detailed teaching points on the back of each card.

Designed for people with mild or moderate developmental disabilities, Horizon I addresses parts of the body, the sexual life cycle, human reproduction, birth control, and sexually transmitted diseases. Life Horizons II addresses building self-esteem and learning to form relationships, moral, legal and social aspects of sexual behaviors (for males), dating skills, marriage and other adult lifestyles, parenting, and preventing or coping with sexual abuse. Each includes over 500 slides, teacher’s guide, and script.

This curriculum offers information on sexual abuse, sexually transmitted infections, and reproductive health, with more than 600 photographs to illustrate 250 vocabulary words relating to sexuality. Appendices include anatomical drawings and information about contraception.

Talking Sex! Practical Approaches and Strategies for Working with People Who Have Developmental Disabilities When the Topic Is Sex—by LT Maurer, MS, CFLE; Planned Parenthood of Tompkins County, 1999

Information, activities, and overheads assist professionals in identifying strategies to improve access to sex education to people with developmental disabilities.

SELECTED RESOURCES FOR PARENTS

Parents have an important role in educating their disabled children about sex. Parents have the best knowledge of their children’s capabilities and of the values the parents want to emphasize. Here are a few recommended resources to help parents.

Books


This beautiful, yet simple book encourages your child to appreciate his/her uniqueness and includes empowering messages about the body, feelings, boundaries, touch, and feeling safe. Its Leader’s Guide of supplemental activities affirms the concepts.

Face Your Feelings—Child's Work / Child's Play. www.childswork.com; 1-800-962-1141

This book and card deck set can help children to understand the importance of expressing and understanding feelings. Designed for ages four and up, the book and card deck include 52 pictures of children, teens, and adults expressing 12 basic feelings.


This easy-to-read story book for young children addresses how boys and girls are different and social rules about talking, looking, touching, and being touched.

What’s Happening to My Body: A Book for Boys—by Lynda and Area Madaras; Newmarket Press, 2000

This straightforward book discusses puberty and the male body. A workbook companion piece entitled, My Body, My Self for Boys, can be purchased separately and includes games, checklists, and quizzes to reinforce what boys have learned.


This straightforward book discusses puberty and the female body. A workbook companion piece entitled, My Body, My Self for Girls, can be purchased separately and includes games, checklists, and quizzes to reinforce what girls have learned.

Sexuality: Your Sons and Daughters with Intellectual Disabilities—by K Schwier and D Hingsburger; Brookes Publishing, 2000

This excellent resource addresses sexual development from birth to adulthood. Parents and their sons and daughters with developmental disabilities share stories that can be helpful. Many portions of the book speak specifically to people with Down syndrome and their parents.
ORGANIZATIONS / WEB SITES

American Association on Mental Retardation (AAMR)
444 North Capitol Street, NW, Suite 846
Washington, DC 20001-1512
Phone: 202-387-1968
Toll free: 1-800-424-3688
Fax: 202-387-2193
www.aamr.org

American Spinal Cord Association
2020 Peachtree Road, NW
Atlanta, Georgia, 30309-1402
Phone: 1-404-355-9772
www.asia-spinalinjury.org

The Arc: National Organization on Mental Retardation
1010 Wayne Avenue, Suite 650
Silver Spring, MD 20910
Phone: 301-565-3842
Fax: 301-565-3843
Fax: 301-565-5342

National Dissemination Center for Children with Disabilities
P.O. Box 1492
Washington, DC 20013
Toll free: 1-800-695-0285
Phone: 202-884-8200
www.nichcy.org

National Spinal Cord Injury Association
6701 Democracy Boulevard, Suite 300-9
Bethesda, Maryland, 20817
Phone: 1-800-962-9629
www.spinalcord.org

Planned Parenthood Federation of America
434 West 33rd St
New York, New York 10001
Phone: 212-247-6269
www.ppfa.org

Sexuality Information and Education Council of the United States (SIECUS)
130 West 42nd Street, Suite 350
New York, NY 10036-7802
Phone: 212-819-9770
Fax: 212-819-9776

Sexuality and Disability Training Center
University Hospital
75 East Newton Street
Boston, MA 02118
Phone: 617-638-7358

Sexual Health Network
www.sexualhealth.com

United Cerebral Palsy
1660 L Street, NW, Suite 700
Washington, DC 20036
Toll free: 800-872-5827
Phone: 202-776-0406
TTY: (202) 973-7197
Fax: (202) 776-0414
www.ucp.org

Written by Dimple Keshav and Barbara Huberman
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Positive Youth Development as a Strategy to Promote Adolescent Sexual and Reproductive Health

Adolescents and young adults in the United States experience negative sexual and reproductive health outcomes, such as sexually transmitted diseases, HIV/AIDS, and pregnancy, at alarmingly high rates. Approximately 745,000 females younger than 20 years of age become pregnant every year. Birth rates among adolescents 15–19 years of age increased 3%, from 2005 to 2006 —the first increase since 1991 [1]. One in four (26%, 3.2 million) young women between 14 and 19 years of age in the United States is infected with at least one of the most common sexually transmitted infections (STIs) [2]. In addition, more than 20,000 males and females 10–24 years of age are living with HIV/AIDS [3].

An essential part of public health is to provide America’s youth with accurate, age-appropriate information about sexual risk reduction, the benefits of abstaining from sex, teen pregnancy, HIV/AIDS, and STI. A number of sex education programs have been developed and shown to effectively reduce sexual risk behavior [4]. However, there is widespread recognition that exposure to even the most effective sex education program is not enough to promote and sustain healthy adolescent sexual and reproductive health outcomes. Sex education approaches alone have short-lived and moderate effects on adolescent sexual risk behavior [5]. Therefore, in addition to evidence-based sex education, adolescents need access to clinical services, and they need efforts that build and/or support other protective factors operating in their family, school, and community [6–9].

Positive youth development (PYD) is a field of study that combines research and programmatic efforts to address other protective factors. PYD seeks to strengthen the adolescent’s ability to respond to developmental challenges in effective ways. PYD may provide the motivation needed for adolescents to apply the skills and knowledge learned in sex education programs. PYD programs help youth to strengthen relationships and skills, embed them in positive networks of supportive adults, and develop a more positive view of their future by providing academic, economic, and volunteer opportunities [6–15].

The Division of Reproductive Health at the Centers for Disease Control and Prevention examined the evidence base for PYD as a strategy to promote healthy adolescent sexual and reproductive health outcomes. To our knowledge, no comprehensive review of this literature is available. Therefore, we partnered with key leaders in the field to compile and synthesize the existing evidence and identify future priorities for research and programmatic activities on the basis of those findings.

Methods

The first challenge was to define PYD program. A wide range of definitions are available in the research and program literature, yet no clear consensus exists. We examined developmental theories, key research syntheses, and program literature to come up with a working definition (Appendix A).

We incorporated into our working definition 12 PYD program goals identified by Catalano et al [10]. The program goals serve as mediating influences through which behavior change occurs. For example, youth with a more positive view of their future, or youth who bond to pro-social adults, may be less likely to take behavioral risks that jeopardize their future goals or harm important relationships (Figure 1).

We chose these goals because they identified a wide range of outcomes and the definitions are derived from theory and empirical research. We expect that more goals will be added over time. We then organized the goals into qualities that are commonly used in the practice community: connectedness (bonding), competence (social, behavioral, cognitive, emotional, and moral competence), confidence (self-efficacy, belief in the future, self-determination, clear and positive identity), and character (pro-social norms, spirituality) [13] (Appendix B).

Roth and Brooks-Gunn [12] proposed that PYD programs can be identified by the types of opportunities
and experiences available to youth. That is, PYD programs seek to strengthen support available to youth in their homes, schools, and communities; help youth build skills; and provide opportunities to engage in real and challenging roles and activities. Another set of PYD program characteristics refers to the atmosphere within which activities are delivered. The atmosphere of the program should support and empower youth, communicate expectations for positive behavior, provide opportunities for recognition, and be stable and relatively long lasting, which allows youth to have adequate time to build relationships and benefit from program activities.

Next, we conducted 2 reviews of the published data. The first review summarized observational research examining the association between the 12 PYD goals and adolescent sexual and reproductive health outcomes, such as initiation of sexual intercourse, use of condoms and/or contraception, number of partners, pregnancy or birth, or having an STI. We were unable to find a review of this scope in the published data and felt that such findings would be necessary to establish the scientific underpinnings of a PYD approach. The second review identified and described the characteristics of PYD programs that attempted to promote adolescent sexual and reproductive health.

Finally, we invited a panel of experts in youth development to review our working definition and preliminary findings from the review of observational and program literature (Appendix C). These experts represented both research and program perspectives. It was important to bring these 2 perspectives together because each had recommended approaches to address common protective factors across development to strengthen youth development while reducing problems. The external experts also provided recommendations for future actions that could be taken in both the research and program arenas.

Summary

This issue presents the results of the reviews of observational and intervention research, and highlights recommendations from the panel of PYD experts.

Four papers summarize the observational research findings. The first paper, by House et al [16], summarizes the findings on social, behavioral, cognitive, emotional, and moral competence. Markham et al [17] summarizes the published data on connectedness or bonding. Gloppen et al [18] describes findings related to confidence (i.e., PYD goals of belief in the future, self-determination, clear and positive identity, self-efficacy). The fourth paper, by House et al [19], addresses character, which includes the PYD goals of pro-social norms and spirituality. A common approach for determining the strength of evidence for whether the PYD outcome predicted adolescent sexual and reproductive health outcomes was used across the 4 reviews. Our findings discuss how PYD outcomes are associated with adolescent sexual and reproductive health, highlight key areas where knowledge gaps exist, and suggest future research and program priorities to expand the evidence base. To our knowledge, observational research has not been summarized using these approaches.

One paper summarizes the PYD intervention research [20]. This synthesis updates the review conducted by Catalano et al [10], but with a focus only on programs in which the evaluation included an examination of the program’s effect on at least one adolescent’s sexual and reproductive health outcome. It finds that there are, indeed, a growing number of PYD programs, with evidence of promoting adolescent sexual and reproductive health. The paper also confirms some of the earlier published data about the key characteristics of PYD programs.

Finally, Catalano et al [21] set a vision for the future by presenting the research and program actions that will best move the field forward. When identifying future priorities, the authors draw on the lessons learned from years of research, findings from the systematic published data reviews conducted, and expert recommendations from the panel convened in December 2007. They highlight the role PYD can play in promoting adolescent sexual and reproductive health, but also call for an expanded focus to include other benefits of these programs, such as improved academic achievement and reduced levels of substance use and violence.

This journal issue provides an unprecedented compilation of the existing evidence for youth development as a strategy to promote adolescent sexual and reproductive health. Although further confirmatory research is needed, we conclude that there is compelling observational and controlled trial evidence that youth development programs can help youth develop the motivation, skills, and confidence needed to make healthy decisions. By combining youth development approaches with the provision of accurate, age-appropriate, and evidence-based sex education, as well...
as access to clinical reproductive health services, the nation is far more likely to achieve sustain and a high degree of sexual and reproductive health among its youth.

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References


Appendix A. Working Definition of PYD Programs
Promoting Adolescent Sexual and Reproductive Health

Youth development has been described as “the ongoing growth process in which all youth are engaged in attempting to meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and to build skills and competencies that allow them to function and contribute in their daily lives” [13]. Therefore, PYD programs that promote adolescent sexual and reproductive health are intentional efforts to promote positive developmental outcomes for young people. The potential for realizing positive youth outcomes starts at birth and continues through early adulthood; therefore, it is important to provide the needed supports along the developmental continuum. Family, peer groups, school, and community influence a youth’s development, thus resulting in youth development programs that take place in multiple settings. High-quality youth development programs are characterized by the presence of goals that promote positive development, the creation of opportunities and experiences that enable young people to nurture their interests and talents, practice new skills, and gain a sense of confidence, competence and belief in the future, and the creation of an atmosphere of hope and the valuing of youth.

Goals

PYD program goals should foster one or more of the following developmental outcomes in youth:

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• Connectedness–pro-social and bonding.
• Competence–cognitive, social, behavioral, emotional, and moral.
• Character–spirituality and pro-social norms.
• Confidence–self-efficacy, belief in the future, self-determination, clear and positive identity [7, 12, 13].

Opportunities and experiences

Programs seek to strengthen supports available to youth at home, school, and in their community, provide formal and informal opportunities for youth to practice new skills, and nurture their interests and talents [10, 12]. The program strengthens developmental supports, for example, through parenting classes that promote bonding by teaching parents better ways to communicate with, set and reinforce behavioral expectations for their child; teacher training to strengthen teachers’ ability to build competencies in youth; modifying the school climate or structure to create more opportunities for pro-social involvement; or changing community attitudes or norms. They help youth build skills (cognitive, social, behavioral, emotional, or moral), for example, through a competency-building curriculum, direct academic instruction, homework help, community service. Programs provide opportunities to engage in real and challenging roles and activities by exposing them to new people, places, and situations. Examples of real and challenging roles include designing, writing, and producing a newspaper, employment, or peer mediation, decision making in families, schools, and communities, and community service. Examples of activities that broaden youth’s horizons include visiting a museum or college campus, engaging in a new sport or recreational activity, cultural activities, and having a pro-social mentor who helps them experience these roles and activities.

Atmosphere

The program creates an atmosphere of hope and an atmosphere where youth feel valued [10, 12]. It does so by being supportive, for example, by encouraging youth to develop a supportive relationship with program staff and adults involved in the program, and encouraging a sense of belonging or bonding with other program participants. The atmosphere of the program is empowering, for example, by encouraging youth to engage in useful roles, practice self-determination, and develop or clarify their goals for the future. The programs convey a belief that adolescents are capable individuals when they communicate expectations for positive behavior. The program can achieve this by defining clear rules for behavior and consequences for infractions, and by fostering pro-social norms and encouraging youth to practice healthy behaviors. Programs can provide opportunities for recognition by rewarding positive behaviors within the program, or by structuring opportunities for public recognition of skills. Programs should be stable and relatively long-lasting to give youth adequate time to build relationships and benefit from program activities.

Appendix B. Definitions of PYD Program Goals

Bonding (connectedness)

For this review, a program was classified as promoting bonding if one or more of its components focused on developing the child’s relationship with a healthy adult, positive peers, school, community, or culture.

Social competence

Social competence is the range of interpersonal skills that help youth integrate feelings, thinking, and actions in order to achieve specific social and interpersonal goals. Programs were classified as promoting social competence if they provided training in developmentally appropriate interpersonal skills, and rehearsal strategies for practicing these skills. These skills included communication, assertiveness, refusal and resistance, conflict-resolution, and interpersonal negotiation strategies for use with peers and adults.

Emotional competence

Emotional competence is the ability to identify and respond to feelings and emotional reactions in oneself and others. Five elements of emotional competence have been identified, including knowing one’s emotions, managing emotions, motivating oneself, recognizing emotions in others, and handling relationships. Programs were classified as promoting emotional competence if they sought to develop youth skills for identifying feelings in self or others, skills for managing emotional reactions or impulses, or skills for building the youth’s self-management strategies, empathy, self-soothing, or frustration tolerance.

Cognitive competence

Cognitive competence includes two overlapping but distinct sub-constructs. The first form of cognitive competence is the “ability to develop and apply the cognitive skills of self-talk, the reading and interpretation of social cues, using steps for problem-solving and decision-making, understanding the perspective of others, understanding behavioral norms, a positive attitude toward life, and self awareness.” The second aspect of cognitive competence is related to academic and intellectual achievement. The emphasis here is on the development of core capacities including the ability to use logic, analytic thinking, and abstract reasoning. A program was classified as promoting cognitive competence if it sought to influence a child’s cognitive abilities, processes, or outcomes, including academic performance, logical and

a For more complete definitions and citations to original sources see reference 10.
analytic thinking, problem-solving, decision-making, planning, goal-setting, and self-talk skills.

**Behavioral competence**

Behavioral competence refers to effective action. Three dimensions of behavioral competence have been identified: “Nonverbal communication (through facial expressions, tone of voice, style of dress, gesture or eye contact), verbal communication (making clear requests, responding effectively to criticism, expressing feelings clearly), and taking action (helping others, walking away from negative situations, participating in positive activities).” Programs were classified as promoting behavioral competence if they taught skills and provided reinforcement for effective behavior choices and action patterns, including nonverbal and verbal strategies.

**Moral competence**

Moral competence is a youth’s ability to assess and respond to the ethical, affective, or social justice dimensions of a situation. A program was classified as promoting moral competence if it sought to promote empathy, respect for cultural or societal rules and standards, a sense of right and wrong, or a sense of moral or social justice.

**Self-determination**

Self-determination is the ability to think for oneself, and to take action consistent with that thought. Programs were classified as promoting self-determination if their strategies sought to increase youths’ capacity for empowerment, autonomy, independent thinking, or self-advocacy, or their ability to live and grow by self-determined internal standards and values (may or may not include group values).

**Self-efficacy**

Self-efficacy is the perception that one can achieve desired goals through one’s own action. Programs were classified as fostering self-efficacy if their strategies included personal goal-setting, coping and mastery skills, or techniques to change negative self-efficacy expectancies or self-defeating cognitions.

**Clear and positive identity**

Clear and positive identity is the internal organization of a coherent sense of self. The construct is associated with the theory of identity development emerging from studies of how children establish their identities across different social contexts, cultural groups, and genders. Programs were classified as fostering clear and positive identity if they sought to develop healthy identity formation and achievement in youth, including positive identification with a social or cultural sub-group that supports their healthy development of sense of self.

**Belief in the future**

Belief in the future is the internalization of hope and optimism about possible outcomes. This construct is linked to studies on long-range goal setting, belief in higher education, and beliefs that support employment or work values. Programs which sought to influence a child’s belief in his or her future potential, goals, options, choices, or long range hopes and plans were classified as promoting belief in the future. Strategies included guaranteed tuition to postsecondary institutions, school-to-work linkages, future employment opportunities, or future financial incentives to encourage continued progress on a pro-social trajectory. Belief in the future could also be fostered by programs designed to influence youth’s optimism about a healthy and productive adult life.

**Spirituality**

Spirituality is defined as “relating to, consisting of, or having the nature of spirit; concerned with or affecting the soul; of, from, or relating to God; of or belonging to a church or religion.” Programs were classified as fostering spirituality if they promoted the development of beliefs in a higher power, internal reflection or meditation, or supported youth in exploring a spiritual belief system, or sense of spiritual identity, meaning, or practice.

**Pro-social norms**

Programs that foster pro-social norms seek to encourage youth to adopt healthy beliefs and clear standards for behavior through a range of approaches. These may include providing youth with data about the small numbers of people their age who use illegal drugs, so that they decide that they do not need to use drugs to be “normal”; encouraging youth to make explicit commitments in the presence of peers or mentors, not to use drugs or to skip school; involving older youth in communicating healthy standards for behavior to younger children; or encouraging youth to identify personal goals and set standards for themselves that will help them achieve these goals. Programs were classified as fostering pro-social norms if they used strategies for encouraging youths to develop clear and explicit standards for behavior that minimized health risks and supported pro-social involvement.

**Appendix C. Panel of Expert Consultants**

Joseph Allen, Ph.D., Professor of Psychology, University of Virginia, Charlottesville, VA.

Richard Catalano, Ph.D., Director, Social Development Research Group, University of Washington, Seattle, WA.

Leslie Clark, Ph.D., Children's Hospital Los Angeles, Los Angeles, CA.

Meryl Cohen, M.Ed., LCSW, Planned Parenthood, Houston, TX.

Brian Flay, D.Phil., Professor, Oregon State University, Corvallis, OR.
Marie Harvey, Dr.P.H., Professor and Chair, Department of Public Health, Oregon State University, Corvallis, OR.
Gabriel Kuperminc, Ph.D., Associate Professor, Georgia State University, Atlanta, GA.
Kimberly Lopez, Dr.P.H., St. Luke’s Episcopal Health Charities, Houston, TX.
Christine Markham, Ph.D., Assistant Professor, University of Texas Health Sciences Center, Houston, TX.
Roy Oman, Ph.D., Professor, University of Oklahoma Health Sciences Center, Oklahoma City, OK.
Polly Padgett, SC Campaign to Prevent Teen Pregnancy, Columbia, SC.
Guillermo Prado, Ph.D., Associate Professor, University of Miami Center for Family Studies, Miami, FL.

Jane Quinn, M.A. Executive Assistant Director, The Children’s Aid Society, New York, NY.
Belinda Reininger, Dr.P.H., Assistant Professor, University of Texas Health Science Center, Brownsville, TX.
Michael Resnick, Ph.D., Professor and Center Director, University of Minnesota Healthy Youth Development-Prevention Research Center, Minneapolis, MN.
Sharon Rodine, M.Ed., Youth Initiatives Director, Oklahoma Institute for Child Advocacy, Oklahoma City, OK.
Karen Tepper, Ph.D., Assistant Research Scientist, University of Arizona, Tucson, AZ.
Susan Tortolero, Ph.D., Director-Center for Health Promotion and Prevention Research, University of Texas Health Science Center-Houston, Houston, TX.
**Sexual Violence**

**Facts at a Glance**

<table>
<thead>
<tr>
<th>Adults</th>
<th>2012</th>
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<tbody>
<tr>
<td>In a nationally representative survey of adults:¹</td>
<td>A 2011 survey of high school students found that 11.8% of girls and 4.5% of boys from grades 9-12 reported that they were forced to have sexual intercourse at some time in their lives.³</td>
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<tr>
<td>• Nearly 1 in 5 (18.3%) women and 1 in 71 men (1.4%) reported experiencing rape at some time in their lives.</td>
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<td>• Approximately 1 in 20 women and men (5.6% and 5.3%, respectively) experienced sexual violence other than rape, such as being made to penetrate someone else, sexual coercion, unwanted sexual contact, or non-contact unwanted sexual experiences, in the 12 months prior to the survey.</td>
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<td>• 4.8% of men reported they were made to penetrate someone else at some time in their lives.</td>
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<td>• 13% of women and 6% of men reported they experienced sexual coercion at some time in their lives.</td>
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<th>College Age</th>
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<tr>
<td>In a nationally representative survey of adults, 37.4% of female rape victims were first raped between ages 18-24.¹</td>
<td>• Among female rape victims, perpetrators were reported to be intimate partners (51.1%), family members (12.5%), acquaintances (40.8%) and strangers (13.8%).</td>
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<td>In a study of undergraduate women, 19% experienced attempted or completed sexual assault since entering college.²</td>
<td>• Among male rape victims, perpetrators were reported to be acquaintances (52.4%) and strangers (15.1%).</td>
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<tr>
<td>• Among male victims who were made to penetrate someone else, perpetrators were reported to be intimate partners (44.8%), acquaintances (44.7%) and strangers (8.2%).</td>
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<tr>
<th>Children and Youth</th>
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<td>In a nationally representative survey:¹</td>
<td>• Among high school students, 12.5% of American Indian/Alaska Natives, 10.5% of Native Hawaiian/Pacific Islander students, 8.6% of black students, 8.2% of Hispanic students, 7.4% of white students, and 13.5% of multiple-race students reported that they were forced to have sexual intercourse at some time in their lives.³</td>
</tr>
<tr>
<td>• 42.2% of female rape victims were first raped before age 18.</td>
<td>• Among adult women surveyed in 2010, 26.9% of American Indian/Alaska Natives, 22% of non-Hispanic blacks, 18.8% of non-Hispanic whites, 14.6% of Hispanics, and 35.5% of women of multiple races experienced an attempted or a completed rape at some time in their lives.¹</td>
</tr>
<tr>
<td>• 29.9% of female rape victims were first raped between the ages of 11-17.</td>
<td></td>
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<tr>
<td>• 12.3% female rape victims and 27.8% of male rape victims were first raped when they were age 10 or younger.</td>
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Sexual Violence Facts at a Glance

Non-fatal Injuries, Medical Treatment, and Health conditions

- Among sexual violence victims raped since their 18th birthday, 31.5% of women and 16.1% of men reported a physical injury as a result of a rape. 36.2% of injured female victims received medical treatment.4
- During 2004-2006, an estimated 105,187 females and 6,526 males aged 10-24 years received medical care in U.S. emergency departments as a result of nonfatal injuries sustained from a sexual assault.5
- Based on 2005 data from the Behavioral Risk Factor Surveillance System (BRFSS), for both women and men, links were found between history of nonconsensual sex and high cholesterol, stroke and heart disease; female victims of nonconsensual sex were more likely to report heart attack and heart disease compared to non-victims.6
- Rape results in about 32,000 pregnancies each year.7
- Among female victims of partner violence who filed a protective order, 68% reported they were raped by their intimate partner and 20% reported a rape-related pregnancy.8

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1-800-CDC-INFO (232-4636) • cdcinfo@cdc.gov • www.cdc.gov/violenceprevention

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www.nctsn.org/sites/default/files/assets/pdfs/Case_Example_karen.pdf
APPENDIX D

LESSON PLANS FOR OT 451:
MULTICULTURAL COMPETENCY IN OT

The lesson plans may be incorporated into the existing course curricula with the discretion of the instructor. There are two learning activities included. A supplementary article is recommended as an additional resource for class facilitation.

1. Heterosexual Questionnaire and handout
2. The Multidimensional Sexuality Questionnaire (MSQ)

Recommended Article:

Recommended Assessment for Purchase:
1. Trueblood Sexual Attitudes Questionnaire (TSQ)
Heterosexual Questionnaire
A Lesson Plan from Creating Safe Space for GLBTQ Youth: A Toolkit

**Purpose:** To give straight people an opportunity to experience the types of questions that are often asked of gay, lesbian, and/or bisexual people

**Time:** 40 minutes

**Materials:** Handout Heterosexual Questionnaire

**Procedure:**
Explain to the group that, when gay, lesbian, and bisexual youth are beginning to 'come out,' they are often asked questions that are nearly impossible to answer. In order to help participants understand the heterosexist bias* in our culture, you will ask them to grapple with these same questions in regard to heterosexuality.

Say that you will give them each a handout. They will break up into groups of four or five and try to come up with answers. Say that you want them to try to answer each question as well as to react to the questions as a whole. Irrespective of each participant's sexual orientation, everyone should attempt to answer as though he/she is heterosexual.

After about 10 minutes, ask everyone to reassemble in the large group. Ask the participants the Discussion Questions below.

**Discussion Questions:**
- Did you find the questions hard to answer?
- Were some harder than others? Which? What, specifically, was so difficult?
- How did the questions make you feel?
- What does it say about our society that gay, lesbian, and bisexual youth are asked similar questions?
- What can you do in the future if you hear someone asking such questions?

- Heterosexist bias, or heterosexism, is the assumption that everyone is, or ought to be, heterosexual and that heterosexuality is the only 'normal,' right, and moral way to be and that, therefore, anyone with a different sexual orientation is 'abnormal,' wrong, and immoral.

Created by Martin Rochlin, Ph.D., January 1977, and adapted with permission. © 2001
http://www.advocatesforyouth.org/for-professionals/lesson-plans-professionals/223?task=view
Handout for Heterosexual Questionnaire Lesson Plan

Please answer the following questions as honestly as possible.

- What do you think caused your heterosexuality?
- When and how did you first decide you were heterosexual?
- Is it possible that your heterosexuality is just a phase you may grow out of?
- Is it possible that your heterosexuality stems from a fear of others of the same sex?
- If you have never slept with a member of your own sex, is it possible that you might be gay if you tried it?
- If heterosexuality is normal, why are so many mental patients heterosexual?
- Why do you heterosexual people try to seduce others into your lifestyle?
- Why do you flaunt your heterosexuality? Can't you just be who you are and keep it quiet?
- The great majority of child molesters are heterosexual. Do you consider it safe to expose your children to heterosexual teachers?
- With all the societal support that marriage receives, the divorce rate is spiraling. Why are there so few stable relationships among heterosexual people?
- Why are heterosexual people so promiscuous?
- Would you want your children to be heterosexual, knowing the problems they would face, such as heartbreak, disease, and divorce?
The Multidimensional Sexuality Questionnaire (MSQ)

William E. Snell, Jr., SE Missouri State University
Terri D. Fisher, The Ohio State University at Mansfield
Andrew S. Walters, University of Georgia

INSTRUCTIONS: Listed below are several statements that concern the topic of sexual relationships. Please read each item carefully and decide to what extent it is characteristic of you. Some of the items refer to a specific sexual relationship. Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be. Then, for each statement fill in the response on the answer sheet that indicates how much it applies to you by using the following scale:

A = Not at all characteristic of me.
B = Slightly characteristic of me.
C = Somewhat characteristic of me.
D = Moderately characteristic of me.
E = Very characteristic of me.

1. I am confident about myself as a sexual partner.
2. I think about sex all the time.
3. My sexuality is something that I am largely responsible for.
4. I am very aware of my sexual feelings.
5. I'm very motivated to be sexually active.
6. I feel anxious when I think about the sexual aspects of my life.
7. I'm very assertive about the sexual aspects of my life.
8. I am depressed about the sexual aspects of my life.
9. The sexual aspects of my life are determined mostly by chance happenings.
10. I sometimes wonder what others think of the sexual aspects of my life.
11. I am somewhat afraid of becoming sexually involved with another person.
12. I am very satisfied with the way my sexual needs are currently being met.
13. I am a pretty good sexual partner.
14. I think about sex more than anything else.
15. The sexual aspects of my life are determined in large part by my own behavior.
16. I'm very aware of my sexual motivations.
17. I'm strongly motivated to devote time and effort to sex.
18. I'm worried about the sexual aspects of my life.
19. I'm not very direct about voicing my sexual preferences. (R)
20. I am disappointed about the quality of my sex life.
21. Most things that affect the sexual aspects of my life happen to me by accident.
22. I'm very concerned with how others evaluate the sexual aspects of my life.
23. I sometimes have a fear of sexual relationships.
24. I am very satisfied with my sexual relationship.
25. I am better at sex than most other people.
26. I tend to be preoccupied with sex.
27. I am in control of the sexual aspects of my life.
28. I tend to think about my sexual feelings.
29. I have a strong desire to be sexually active.
30. Thinking about the sexual aspects of my life leaves me with an uneasy feeling.
31. I am somewhat passive about expressing my sexual desires. (R)
32. I feel discouraged about my sex life.
33. Luck plays a big part in influencing the sexual aspects of my life.
34. I'm very aware of what others think of the sexual aspects of my life.
35. I sometimes am fearful of sexual activity.
36. My sexual relationship meets my original expectations.
37. I would rate myself pretty favorably as a sexual partner.
38. I'm constantly thinking about having sex.
39. The main thing which affects the sexual aspects of my life is what I myself do.
40. I'm very alert to changes in my sexual desires.
41. It's really important to me that I involve myself in sexual activity.
42. I usually worry about the sexual aspects of my life.
43. I do not hesitate to ask for what I want in a sexual relationship.
44. I feel unhappy about my sexual relationships.
45. The sexual aspects of my life are largely a matter of (good or bad) fortune.
46. I'm concerned about how the sexual aspect of my life appears to others.
47. I don't have very much fear about engaging in sex. (R)
48. My sexual relationship is very good compared to most.
49. I would be very confident in a sexual encounter.
50. I think about sex the majority of the time.
51. My sexuality is something that I myself am in charge of.
52. I am very aware of my sexual tendencies.
53. I strive to keep myself sexually active.
54. I feel nervous when I think about the sexual aspects of my life.
55. When it comes to sex, I usually ask for what I want.
56. I feel sad when I think about my sexual experiences.
57. The sexual aspects of my life are a matter of fate (destiny).
58. I'm concerned about what other people think of the sexual aspects of my life.
59. I'm not very afraid of becoming sexually active. (R)
60. I am very satisfied with the sexual aspects of my life.
61. I responded to the above items based on:
   (A) A current sexual relationship.
   (B) A past sexual relationship.
   (C) An imagined sexual relationship.

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Scoring Instructions for the Multidimensional Sexuality Questionnaire (MSQ)

Purpose
The Multidimensional Sexuality Questionnaire (MSQ; Snell, Fisher, & Walters, 1993) is an objective, self-report instrument designed to measure of 12 aspects of human sexuality: (1) sexual-esteem, defined as positive regard for and confidence in the capacity to experience one's sexuality in a satisfying and enjoyable way; (2) sexual-preoccupation, defined as the tendency to think about sex to an excessive degree; (3) internal-sexual-control, defined as the belief that the sexual aspects of one's life are determined by one's own personal control; (4) sexual-consciousness, defined as the tendency to think and reflect about the nature of one's sexuality; (5) sexual-motivation, defined as the desire to be involved in a sexual relationship; (6) sexual-anxiety, defined as the tendency to feel tension, discomfort, and anxiety about the sexual aspects of one's life; (7) sexual-assertiveness, defined as the tendency to be assertive about the sexual aspects of one's life; (8) sexual-depression, defined as the experience of feelings of sadness, unhappiness, and depression regarding one's sex life; (9) external-sexual-control, defined as the belief that one's sexuality is determined by influences outside of one's personal control; (10) sexual-monitoring, defined as the tendency to be aware of the public impression which one's sexuality makes on others; (11) fear-of-sex, defined as a fear of engaging in sexual relations with another individual; and (12) sexual-satisfaction, defined as the tendency to be highly satisfied with the sexual aspects of one's life. Factor analysis (12 factor maximum likelihood with oblique rotation) confirmed that the items on the Multidimensional Sexuality Questionnaire largely form conceptual clusters corresponding to the 12 MSQ concepts (Snell et al., 1993). Other results indicated that all 12 subscales had clearly acceptable levels of reliability (alphas ranged from .71 to .94, with an average of .85; test-retest reliabilities ranged from .50 to .86, with an average of .87). The 12 MSQ subscales were also found to be largely uncontaminated by social desirability tendencies. Additional findings indicated that men reported higher levels of sexual-esteem, sexual-preoccupation, sexual-motivation, sexual-assertiveness, and external-sexual-control than did women. By contrast, females reported greater fear-of-sexual-relations than did males. Other results indicated that the MSQ subscales were related to both exchange and communal approaches to sex, to sexual attitudes, and to women=s and men=s sexual behaviors. Scores in the Multidimensional Sexuality Questionnaire can be treated as individual difference measures of the 12 constructs measured by the MSQ or as dependent variables when examining predictive correlates of these concepts.

Description
The Multidimensional Sexuality Questionnaire consists of 60 items arranged in a format where respondents indicate how characteristic of them each statement is. A 5-point Likert scale is used to collect data on peoples' responses, with each item being scored from 0 to 4: Not at all characteristic of me (0), Slightly characteristic of me (1), Somewhat characteristic of me (2), Moderately characteristic of me (3), and Very characteristic of me (4). In order to create subscale scores (discussed below), the items on each subscale are summed. Higher scores thus correspond to greater amounts of the relevant tendency. To confirm the conceptual dimensions assumed to underlie the
Multidimensional Sexuality Questionnaire, the 60 items on the MSQ were subjected to a 12 factor maximum likelihood factor analysis with oblique rotation. A 12 factor solution was specified and rotated to oblique structure with the oblimin procedure. The results of this statistical analysis provided preliminary evidence supporting the anticipated factor structure of the Multidimensional Sexuality Questionnaire.

Response Mode and Timing
In most instances, people respond to the 60 items on the Multidimensional Sexuality Questionnaire by marking their answers on separate machine-scorable answer sheets. The scale usually requires about 30-45 minutes to complete.

Scoring
The Multidimensional Sexuality Questionnaire consists of 60 items. Several items are first reverse coded (items 19, 31, 47, and 50); they are designated with an "R" on the copy of the MSQ shown below. The relevant items on each subscale are then coded so that A = 0; B = 1; C = 2; D = 3; and E = 4. Next, the items on each subscale are summed, so that higher scores correspond to greater amounts of each tendency. Scores on the 12 subscales can range from 0 to 20. The items on the MSQ subscales alternate in numerical order (i.e., subscale 1 consists of items 1, 13, 25, 37, and 49; subscale 2 consists of items 2, 14, 26, 38, and 50).

Reliability
The internal consistency of the subscales on the Multidimensional Sexuality Questionnaire was determined by calculating Cronbach alpha coefficients, using 372 participants (265 females; 117 males; 4 gender unspecified) drawn from lower division psychology courses at a small Midwestern university (Snell et al., 1993). The average age of the sample was 24.1, with a range of 17 to 60. The alpha coefficients were computed for each of the 12 subscales. Each coefficient was based on 5 items. The alphas for all subjects on the 12 subscales were .87, .94, .80, .71, .91, .83, .77, .92, .86, .90, .82, and .90 (for subscales 1 to 12, respectively). Test-retest reliability were, respectively: .85, .73, .63, .75, .83, .64, .65, .70, .68, .69, .67, and .76. In brief, the 12 MSQ subscales had more than adequate internal consistency and test-retest reliability.

Validity
Evidence for the validity of the Multidimensional Sexuality Questionnaire (MSQ) comes from a variety of findings. Snell et al. (1993) found that among university students, women's and men's scores on the MSQ were associated not only with their sexual attitudes and their exchange and communal approaches to sexual relations, but also with their scores on other instruments conceptually similar to the MSQ. Men=s and women=s sexual behaviors were also predictably related to their scores on the MSQ subscales. Additional research provides evidence that the MSQ subscales were related in predictable ways to men's and women's contraceptive behaviors (Fisher et al., 1995).
References

Permission granted by William E. Snell, Jr. on April 2, 2014.
REFERENCES


APPENDIX E

LESSON PLANS FOR OT 453: PHYSICAL ASPECTS OF OT WITH THE MATURING ADULT

The lesson plan may be incorporated in to the existing course curricula with the discretion of the instructor. There is one learning activity included.

1. Physical Disability and Sexuality
   • Power point

Recommended Adaptive Equipment for Purchase:
   1. Waist or thigh strap on with dildo (www.amazon.com)
   2. Vibrator (www.amazon.com)
   3. Tongue vibrator (www.amazon.com)
   4. Liberator wedge/ramp (www.liberator.com)
Physical Disability and Sexuality

Physical illness or injury has the ability to impact an individual in many different ways including their sexuality. Physical illness and injury varies and the impact it has on each individual will also vary, which is why strategies and interventions must vary depending on the illness or injury and the individual. Occupational therapy students should be given the opportunity to understand specific strategies and adaptive equipment to be utilized for specific physical illness or injury. Discussion on the use of adaptive equipment, adaptive positioning, and video demonstrations will increase the level of competence and confidence of addressing sexual concerns with future clients.

**Learning objectives:** Following completion of the lesson plan.

1. Understand the impact of physical illness or injury on sexuality and sexual functioning.
2. Develop a comfort level with the use of adaptive sexual equipment and adaptive sexual positioning.
3. Develop and understanding of proper adaptive sexual equipment and adaptive sexual positioning for specific diagnosis and/or impairments.

**Getting Started:**
1. *Have students read prior to class:*

Discussion questions may include:

- How do you view the role of occupational therapy in addressing sexual concerns related to physical disabilities?
- Discuss your comfort level in addressing sexual concerns with physical disabilities?
- Was this information sufficient in providing you with specific strategies for sexual adaptations?
- What information do you feel you are still lacking in order to competently and confidently address sexual concerns with clients in a physical disabilities setting?

2. *PowerPoint slides:* A PowerPoint on specific adaptive equipment and positioning for specific physical disabilities or limitations.
Adaptive Equipment and Positioning for Sexual Dysfunction

Sensorimotor Sexual Problems

- Sensory loss (CVA, SCI, MS, neuropathies): Focus on intact senses and intact touch. Protect skin where sensation is diminished.

- Decreased Movement (weakness, poor tone, paralysis, MS, TBI, SCI, arthritis): Partner is more active. Change position to require less movement. Change sexual activity to that of manual/oral stimulation.

- Decreased ROM (burns, hip fracture, total hip replacement precautions): Position to accommodate contractures and ROM precautions.

- Pain (burns, trauma, back problems): Time sexual activity to medication schedule, relaxation/pain management techniques and positioning.

- Decreased Endurance (COPD, MS, cancer, cardiac conditions): Positioning, schedule activity after rest, conserve energy, partner more active role, change to less stressful sexual activity such as manual/oral stimulation.

  (Fromm, 1997)
Cognitive/Perceptual Problems

- Decreased Attention Span (CVA, TBI): control environment to decrease external stimuli
- Hemihemianattention (CVA): position partner to unaffected side.
- Apraxia (CVA, TBI): use uncomplicated positions develop a routine.

OTHER

- Bowel or Bladder Incontinence (MS, TBI): empty bladder before sexual activity, time sex to bowel problem, keep towels available for clean up, communication with partner about possible accident.
  [ cited from Friedman, 1997]

Positioning

- One Partner on Top: Experiment with the “top” and “bottom” partner for sexual movement such as thrusting. Use pillows behind the lower back/or knees for the “bottom” partner for support which can help alleviate spasms, reduce lower back pain and offer easier access to the genitals.
Positioning

- Side-Lying Position: can be done in a spoon position when one partner lies in front of the other, both facing the same direction or in side positions facing each other. The spooning side-lying position is useful for people with catheters and have a leg bag, along with having a cushion between the person’s leg to ease hip discomfort and facilitate penetration or sexual acts from behind. The side-lying facing each other is beneficial because both partners can be involved in thrusting of penetration or sexual act.

- Using a Chair or Wheelchair: Armrests may want to be removed if possible. The “top” partner can sit on their partner’s lap either face to face or facing away. The person in the wheelchair can also receive penetration or oral sex by moving their buttocks to the edge of the chair and having their partner kneel or sit in front of them.

- If arm rests are unable to be removed they may be used for additional support, or the couple can also transfer to a chair with no armrests to increase ease of positioning.
Positioning

- Supportive Rear Positions: The “bottom” partner should lie on his/her stomach with the “top” partner standing or kneeling behind their partner. The “bottom” partner can be lying at the edge of a bed, table, couch, etc. This positioning provides optimal balance for the “bottom” person and allows them to help with more thrusting.

Adaptive Equipment

- No hand function
- Tongue Vibrator

- Waist/thigh harness and dildo
Adaptive Equipment

- Limited Hand Function and Strength in Upper Extremity
- Vibrator with or without universal cuff

Adaptive Equipment

- Limited Flexibility for Positioning

- Intimate Rider demonstration:
  http://www.youtube.com/watch?v=aSR7VNV223s

- Body Bouncer
  https://www.youtube.com/watch?v=XReuvXZkQ0Q
Adaptive Equipment

- Limited Flexibility for Positioning Cont.
- Thigh Sling – a device which ties around an individual's ankles or knees to allow legs to be elevated towards the head during intercourse.
  - Liberator Shapes
    - https://www.youtube.com/watch?v=PyYMW1GetPI
    - https://www.youtube.com/watch?v=0w89xLHSX3Q

Videos

- Men with SCI: http://www.youtube.com/watch?v=HatRXFL1TbQ
- Women with SCI: http://www.youtube.com/watch?v=98jVQfatK2w
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APPENDIX F

LESSON PLANS FOR OT 454:
GERONTIC OCCUPATIONAL THERAPY

The lesson plan may be incorporated into the existing course curricula with the discretion of the instructor. There is one learning activity included.

1. Sex and the Retirement Community: Sex and the Older Adult
   - Student Reflection
   - Case Studies
   - Videos

Recommended Assessments for Purchase:
1. Kingsberg Brief Assessment (Kingsberg, 2006)
Sex and the Retirement Community: Sex and the Older Adult

Sexuality is at the core of who we are and has an impact on our lives in so many ways. It does not stop once we hit the age of 60 or 70 or 90 or even 100 despite the myths and assumptions of society. Sexual desire does not necessarily dissipate with age, but the physical, cognitive, and psychosocial changes that can occur with aging may interfere with sexual outcomes. Issues of sexuality with older adults often become a taboo topic; whether it is the expression of desire or the inappropriate sexual acting out of the individual with dis-inhibition secondary to dementia.

In the long-term-care environment, expressions of sexuality are frequently labeled as problem behaviors. The number of older adults testing HIV positive is on the rise thereby making safe sex practices a priority topic of discussion for health care professionals. Clearly sexual issues are fairly common among older adults, but the health care team infrequently addresses these issues. Occupational therapists are no different. They frequently report a level of discomfort with initiating discussions of sexual assessment with their patients in general but more so with their patients who are older adults. There are sexuality assessments that are often a sub-section of general assessments, but are often glazed over secondary to the discomfort of the examiner or the hypothesis that it is not of importance to the examiner. Common sexual side effects of medications such as antidepressants are regularly discussed with younger patients but very rarely addressed with older adult patients.

The need to raise a student’s awareness of the complex issues surrounding sexuality of older adults is a focus of this teaching strategy. In addition, this teaching strategy is designed to increase the comfort level of the student through the use of min case studies.

Learning Objectives: Following completion of the lesson plan.
1. Identify the functional, psychosocial, cultural, and cognitive issues that can affect expression of sexuality.
2. Develop a comfort level with assessing the sexuality of their older adult clients.
3. Demonstrate awareness of the link between fulfillment of sexuality and optimal quality of life.
4. Identify the sexual risks and associated interventions of sexuality in the older adult population.
5. Reflect on the impact their own beliefs regarding sexuality have on their perceptions about the needs and expectations of others.

Getting Started:
1. *Have students read prior to class:*
Discussion questions on the article could include:

- What were your thoughts on the impact of older age on sexuality?
- What were your thoughts about the impact of sex on self-esteem and quality of life?
- Describe your comfort level with addressing sexual concerns with older adults.

2. **Student reflection:** This exercise asks students to reflect on their comfort level with talking about sexuality as well as their thoughts on the part sexuality plays in the lives of older adults. These questions can be used as a journal reflection assignment, as questions in an online forum activity, or in small group discussions.

   - What are your thoughts about the importance of sexuality to your patients?
   - Do you think differently about your older adult clients?
   - What makes you uncomfortable when you talk with your clients about issues of sexuality? What are you comfortable talking about?
   - What issues of sexuality do you feel you have a strong bias about? Infidelity? Homosexuality? Sexual abuse? Sex outside of a committed relationship?
   - What do you think are the main teaching points in educating older adults about sexual issues?
   - How would you feel if you were not able to express your sexuality?

3. **Case studies:** A PowerPoint presentation with each slide include a mini case study and some notes for the faculty to guide the discussion of older adults talking about issues of sexuality. Stress to students that these are all real issues brought up in the practice environment to practitioners caring for older adults. The case studies are meant to elicit discussion on how the student would respond if their own patient discussed these issues with them. The case studies serve two purposes: 1) to expose students to questions and discussions clients may initiate and 2) to help build up the comfort level students need when discussing issues of sexuality with older adults.

4. **Videos:** Have students watch videos related to sexual health in older adulthood.
   - [http://www.youtube.com/watch?v=1Pfa07ijUCE](http://www.youtube.com/watch?v=1Pfa07ijUCE)
   - [http://www.youtube.com/watch?v=YKG40Bzwo7E](http://www.youtube.com/watch?v=YKG40Bzwo7E)

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http://www.nln.org/facultyprograms/facultyresources/aces/Sexuality/sexuality.htm

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Sexuality in Older Adulthood

Mini Case Studies
Betty and Sam were married for 54 years, however Sam recently passed away. Betty is discussing with you how much she misses Sam now that he is gone and what she misses the most is his touch. When she lays in bed at night she thinks about Sam and all of their wonderful nights together. Betty discusses with you about her and Sam’s sex life, which was quite satisfying, even though it had changed over the years. Betty also discusses how her sex life with Sam was an important part of who she is and that she still feels the urge to connect in that manner even though Sam is gone. Betty discusses masturbation however states that she is embarrassed at the thought of it but really misses her husband and his touch. What do you discuss with Betty?

Teaching notes: Priority is doing the PLISSIT assessment and talking with her about sexuality as a part of our healthy selves. The fact that she misses her husband in a sexual way is a great indicator of their wonderful relationship.
Teaching notes: Priority should be directed at safe sex practices. The rate of sexually transmitted diseases among older adults is on the rise, specifically HIV with older minority woman per the Center for Disease Control (CDC).
Teaching notes: The priority would be focused on the dis-inhibition (especially of the frontal lobe of the brain) that occurs with dementia. This can often cause a change in personality or disinhibited behaviors never seen previously in the individual. They really have limited control and insight, therefore behavioral modalities rarely work. Environmental modalities can work for example not leaving the client alone with members of the opposite sex, or using distraction when they say inappropriate comments. All members of the health care team including family should be involved in the intervention planning.
Kathy has been in and out of the hospital three different times in the past year and a half. She first broke her hip, then had cancer, now she had to have a mastectomy on her right breast. Kathy has been married to Frank for 50 years and they have always enjoyed each other’s company. Kathy is discussing her concerns with you about her husband seeing her after the mastectomy as well as how attracted to her he will be when they are being intimate together. Kathy states that after she broke her hip her and Frank maintained their level of intimacy with some changes in habits due to her hip, however her looks never changed. Frank always thought Kathy’s breasts were attractive and now Kathy states she feels like less of a woman and is concerned her husband won’t want her sexually anymore. What do you discuss with Kathy?

Teaching notes: The PLISSIT assessment model may be appropriate and would be a good initial approach. In addition the Geriatric Depression Scale might be an appropriate tool to assess for evidence of depression. Clearly the multiple physical issues and accompanied hospitalizations have created a stress that could then contribute to depression. It is important to note that just because the source of the depression and anxiety is apparent does not mean that it should not be treated. In addition a discussion about self-esteem and body image is a direction that might help to open up dialogue with Kathy. Start with an open ended question such as “Tell me how you feel about yourself and has that changed since the surgery.”
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APPENDIX G

LESSON PLANS FOR OT 456:
PSYCHOSOCIAL ASPECTS OF OT WITH THE MATURING ADULT

The lesson plans may be incorporated into the existing course curricula with the discretion of the instructor. There is one learning activity included.

1. Psychological Aspects and Sexuality
   • Self-Esteem
   • Limits
   • Self-Disclosure

Recommended Assessment for Purchase:
1. Burns Anxiety Checklist (Burns, 1999)
Psychological Aspects and Sexuality

Mental illness has the ability to impact individuals in many different ways including their sexuality. Mental illness does not just cause physical problems with the actual act of sex, but it can cause issues on a psychological level in regards to relationships and personal identity. According to Dorsay and Forchuk (1994), sexuality is more than the physical act of engaging in sexual activity and reproduction, but it also encompasses common mental health issues such as self-identity, social functioning, and the ability to form healthy relationships with others in social and intimate ways. In order for occupational therapists to address clients in a holistic manner, the topic of sexuality and the impact mental illness has on their clients should be addressed.

Occupational therapy students should have the opportunity to understand the impact mental illness has on sexual functioning and relationships between partners. Students should also be given the opportunity to learn useful strategies and interventions to incorporate into future practice to address sexual related concerns for clients in a mental health setting. Discussion on the importance of addressing sexuality as well as participation in activities that may be useful in addressing sexual concerns for clients in a mental health setting will increase the student’s comfort level as well as competence.

Learning objectives: Following completion of the lesson plan.
1. Understand the impact of mental illness on sexuality.
2. Develop a comfort level with addressing sexuality in a psychosocial setting.
3. Develop an understanding of the role of occupational therapy in addressing sexuality with clients in a mental health setting.
4. Develop and understanding for and the ability to incorporate activities related to the impact of mental illness on sexuality as interventions.

Getting Started:
1. Have students read prior to class:

Discussion questions may include:

- Describe the impact of mental illness on sexuality?
- What are the important areas to address in clinical practice in terms of sexuality and mental illness and why?
- How comfortable are you with addressing sexuality concerns with individuals in a clinical setting?
- What information did you find surprising in this article?
- How can we as a profession address the issue of sexuality with clients in a mental health setting?
2. *Activities to address areas related to the impact of mental health on sexuality and relationships*: A group of activities will be attached and include activities related to communication, self-esteem, setting limits and coping, as well as maintaining healthy relationships. Some or all of the activities may be utilized for students to participate in for their own personal comfort level as well as competency on how to utilize these activities in a clinical setting and when it is most appropriate. All activities will be provided with a description of the purpose of the activity as well as how to complete activity with possible alternatives. Activities can be conducted in a large group setting with the professor leading the group, or may be done in smaller groups with larger group discussion.

- Self-Esteem
- Limits
- Self-Disclosure
- Body Image Relaxation Technique:

Discussion questions should follow each activity and may include:

- When would you use this activity and for what clients?
- How did you feel discussing personal aspects in a group setting?
- What impact does mental illness have on sexuality and relationships between individuals?
- How will this activity benefit a client in regards to sexuality and relationships?
- How can this activity be adapted?
Self-Esteem

I will climb these necessary "steps" to greater self-appreciation...

&

I will recognize these symptoms of the path to self-defeat....
By setting these limits, I am taking more control of my life, increasing my self-esteem, and establishing boundaries in my relationships.

Signature:
Self-Disclosure

Complete the following statements to gain an increased understanding of your SELF. You may want to DISCLOSE these thoughts and feelings to someone special to enhance your relationship.

- I am most content when

- My hopes and dreams for the future are

- I like myself most when

- I like myself least when

- My greatest fear is

- I feel disappointed when

- People think I am

- I value most

- One negative trait about myself is

- One positive trait about myself is

I'm going to share these thoughts and feelings with.
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