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**A Case for Trauma-Informed Sex Education for Youth in Child Welfare:  
*What is It, Why It Matters, & Who is Responsible? A Training for Dependency Court  
Stakeholders***

A Special Studies Project

By

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An abstract of  
A special studies project to the Faculty of the  
Rollins School of Public Health of Emory University  
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2018

## Abstract

### **A Case for Trauma-Informed Sex Education for Youth in Child Welfare: *What is It, Why It Matters, & Who is Responsible? A Training for Dependency Court Stakeholders***

A Special Studies Project

By Sarah Ashley Jolly

**Background:** Youth in child welfare systems face discrete barriers to sexual health, reproductive health, and healthy relationships education (SRHHRE) and services. This is complicated by a majority of youth's primary and secondary exposures to traumatic events. Dependency court stakeholders are in a unique position to act as trusted adults, negotiators, and advocates for trauma-informed SRHHRE in the lives of youth.

**Purpose:** The purpose of this special studies project is to create a curriculum for child welfare stakeholders that seeks to increase stakeholders' critical awareness of the current state of sex education in the United States that youth in care might be exposed to, with activities and resources that seek to increase and engage participants knowledge of sexual and reproductive health (SRH,) healthy relationships, and pregnancy prevention utilizing a trauma-informed perspective.

**Methods:** Prior to the development of this curriculum, surveys were administered by convenience sampling at nine training sites selected by Power to Decide for the 2017-2018 cycle of the *Training and Technical Assistance Project: Addressing Teen and Unplanned Pregnancy in Dependency and Juvenile Justice Courts*. 194 respondents answered at least one question on the survey; 97% of respondents indicated a first-choice for training expansion, of which 39.7% of respondents reported that trauma-informed SRHHRE was their first preference.

**Results:** This curriculum is stratified by three modules, [1] Sex Education in the United States, [2] Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible? and [3] Sexual and Reproductive Health Resource Overview. Each module includes an activity and/or opportunity for content exploration.

**Discussion & Recommendations:** Access to appropriate and comprehensive SRHHRE and services allows individuals to control their reproductive abilities and sexual health, which has implications for increased opportunities for educational and economic advancements. This curriculum will increase stakeholders' self-efficacy in acting as an advocate and trusted adult in the lives of youth in care to ensure that they have access to developmentally appropriate, trauma-informed SRHHRE with potential implications to improve long-term health outcomes.

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## **I. Introduction & Background**

### **1) Rationale**

This special studies project (SSP) seeks to supplement Power to Decide's pregnancy prevention guide, *"When You Decide..." A Judge's Guide to Pregnancy Prevention Among Foster Youth Curriculum*, with a trauma-informed curriculum focusing on stakeholder engagement with attention to the sexual health, reproductive health, and healthy relationships education (SRHHE) of youth in child welfare. Stakeholders, such as judges, social workers, therapists, probation officers, group home staff, court staff, etc. have expressed a need for a trauma-informed approach to initiate and sustain measures to address SRHHE with youth in order to improve outcomes for youth in care (see Methods). This SSP will illustrate why a trauma-informed approach to SRHHE is necessary, along with an evidence-informed curriculum to facilitate activities and conversations with youth, in order to improve relationships and sexual and reproductive health (SRH) outcomes.

### **2) Significance**

#### ***Sex Education in the United States***

The state of education on sex, sexuality, and relationships in the United States is precarious at best. Oregon is the only state that mandates (ORS 336.455) statewide educational standards for comprehensive sex education at all grade levels. Only 20 states require that the information included in sex education meet standards for medical, factual, or technical accuracy. Four states require that parental consent be obtained before youth can participate in sex education courses. (National Conference of State Legislators, 2016 Several states and localities negotiate parental consent – giving parents the right to opt their child in or out of such classes. For youth in the child welfare system, parental contact is inconsistent – if not, completely



nonexistent. This is only one of the barriers that systems-involved youth encounter in receiving comprehensive SRHHRE and services.

Since 1981, nearly two billion dollars in federal funds have been funneled to schools that endorse and teach abstinence-only educational models. (Donovan, 2017) Federal law mandates abstinence-only models must meet several standards, including exclusively teaching the benefits of abstaining from sex until marriage. Additionally, schools must teach that sexual activity outside of marriage will likely result in damaging physical, mental, and emotional side effects. Honoring these standards for abstinence-only education is harmful to youth, especially those that have already had their sexual debut or have been the victim of sexual trauma. Although few studies credibly illustrate the long-term benefits of abstinence-only education, spending for the 2016 fiscal year experienced a \$30 million increase in funds dedicated to abstinence-only education, for a total of \$85 million. (National Conference of State Legislators, 2016) However, many studies cite the benefits of comprehensive sex education. (D. Kirby & Laris, 2009) These benefits can include increased social capital, self-efficacy, and empowerment. Exposure to evidence-based SRHHRE programming has the potential to improve educational, socioeconomic, and personal outcomes.

The National Standards for Sex Education (NSSE) encompass all topics that should be included in a comprehensive, medically accurate sexual health curriculum. (Future of Sex Education Initiative, 2012) The framework for these standards is based on the social ecological model, social learning, and social cognitive theories. The NSSE espouses that curricula should include components of personalization, skills, susceptibility, self-efficacy, and inclusion of social norms. This is to say that curricula should be adapted utilizing existing policies to reflect

concepts that increase youth's skill sets and reflect social norms in a way in which the content is relatable to an individualized experience.

### ***Challenges for Youth in Foster Care***

Youth in care face numerous challenges in order to gain access to SRHHRE programs and services. Barriers to SRHHRE are compounded by institutional constraints found in federal and state-level systems. Youth in foster care are twice as likely to become pregnant before the age of 19 compared to their peers out of care. (Courtney, 2005) A myriad of environmental and personal factors affect teen sexual behavior, pregnancy, and patterns of childbearing. (D. Kirby & Lepore, 2007) Systems-involved youth are often not exposed to protective factors such as a stable two-parent household, school-based SRHHRE, faith communities, and/or positive peer characteristics that deter negative social, economic, and personal outcomes. Access to clinical care is complicated by rising healthcare costs and regional disparities in clinical availability. Additionally, a lack of knowledge, resources, consistent transportation, effective policies, and reliable, trusted adult figures inhibit youth's ability to access SRH care and information.

In order to reduce harm and the incidence of negative SRH and relationship outcomes youth should receive medically accurate, comprehensive, trauma-informed SRHHRE. It is important to address the effects of traumatic experiences in children and adolescents due the evidence linking trauma with lifelong immune dysregulation, which can cause multi-symptomatic expression along with chronic pain. (Sigurdardottir & Halldorsdottir, 2018) Youth in care are more likely to experience negative SRH outcomes. (Courtney, Dworsky, Ruth, Havlicek, & Bost, 2005) It is also likely that youth will have experienced one or more traumatic events in their lifetime, more than 90% of all youth referred to child welfare services have experienced multiple traumatic events. (Stambaugh et al., 2013) Compared to their peers, youth

in foster care are also more likely to have their sexual debut at a younger age. (Boonstra, 2011) This is complicated by the fact that one out of six females in the child welfare system are pregnant or parenting. (Gotbaum, 2005)

### ***The Point of Impact: Stakeholders in the Child Welfare System***

Stakeholders in the child welfare system are charged with the care and wellbeing of youth in the care of the state. Despite the flaws of the child welfare system, for many youth in care, child welfare staff are some of the only consistent adult figures in their lives. Creating an informed team of stakeholders will increase youth's access to trusted adult relationships and knowledge. Increasing stakeholder knowledge of protective factors will positively negotiate youth's access to community resources, social and personal capital. Although askable adults are not expected to be subject-matter experts, they are available to express interest and empathy, answer basic questions, and open doors to additional resources. In the context of SRH, increasing the number askable adults in the lives of youth is imperative. Further, it is necessary that youth in care are supported by knowledgeable, inclusive, askable adults that have had professional development in trauma-informed SRHHRE.

### ***Trauma & Trauma-informed SRHHRE***

According to one report, one in four girls and one in six boys will be sexually abused before the age of 18. (The National Child Traumatic Stress Network, 2009) The prevalence of trauma among foster youth is significant and nearly always underreported. The majority of youth in foster care have experienced multiple traumatic events in their lifetime, simply by the nature of being removed from their biological parent's home. It is already known that youth in foster care report a higher prevalence of mental illness compared to the general population. (Ko et al., 2008; Farmer et al., 2001; Garland et al., 2001) Compared to youth who receive in-home social

services, youth who are referred to out-of-home care (foster care) are more likely to experience trauma. (Kolko et al., 2010) Youth in care are 10 times more likely than youth living with two biological parents to be abused. (Sedlak et al., 2010) However, researchers have identified protective factors impacting known modifiable resilience factors in victims of early childhood adversity that can be easily translated to trauma-informed medical services. (Traub & Boynton-Jarrett, 2017)

To date, there is no universally agreed-upon definition of trauma-informed care. However, a definition from the Substance Abuse and Mental Health Services Administration (SAMSHA) and the American Institutes for Research incorporated several perspectives to define this term:

*Trauma-informed care is a strengths-based service delivery approach “that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services. (DeCandia, Guarino, & Clervil, 2014)*

Trauma-informed services follow the ideology of trauma-informed care by treating individuals holistically in order to address any post-traumatic stress and any co-occurring disorders.

(DeCandia et al., 2014) Generally, social, medical, and legal services are not trauma-informed. It is possible to retraumatize youth through antiquated or uninformed practices. Researchers define retraumatization as:

*“feeling as if the past trauma is reoccurring or as if the treatment experience is as dangerous and unsafe as past traumas. For instance, clients may express feelings of powerlessness or being trapped if they are not actively involved in treatment decisions; if treatment processes or providers mirror specific behavior from the clients’ past experiences with trauma.” (Center for Substance Abuse, 2014)*

While empirical literature focusing on the retraumatization of youth through social services and other systems is limited, there are some descriptive data rooted in the delivery of other service systems that quantifies this issue. For example, a 2003 study that sought to expose retraumatization and harm in psychiatric facilities found that 26% of participants reported witnessing traumatic events, 43.9% reported an event of sexual or physical assault, and 22.8% reported an event of verbal intimidation or abuse. (Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennett, 2003) While this is not directly related to the experience of youth in care, it does represent institutional neglect of trauma-informed practices that are persistent in virtually all levels of child welfare related services.

The principles of trauma-informed care should be translated and practiced in youth's receipt of SRHHRE. Child welfare stakeholders and staff should act as negotiators and advocates for youth's right to developmentally appropriate and comprehensive SRHHRE. This includes being critically aware of SRH programing and education that has the potential to retraumatize youth. Trauma-informed SRHHRE can improve youth's receptivity to SRHHRE and services. This can also increase the strength of trusted/askable adult relationships. SRHHRE and the related services are positively associated with SRH-related outcomes, such as delayed sexual debut, declines in STI rates, and unplanned pregnancies which have further implications to the fulfillment of education, economic, and social advancement. (D. B. Kirby, 2008; D. B. Kirby, Laris, & Rolleri, 2007)

### 3) Problem Statement

Youth involved in the child welfare system face discrete barriers to improving social, economic, and personal outcomes as potential implications of insufficient access to comprehensive SRHHRE. Access to comprehensive SRHHRE for youth in care is complicated

by institutional barriers and increased risk of retraumatization by traditional SRHHRE curricula. Stakeholders across the United States have expressed a need for increased professional development on trauma-informed SRHHRE-related topics. Trainings must be focused on conversational tools and resources that stakeholders can effectively utilize in the lives of youth to improve overall outcomes.

#### 4) Purpose Statement

The purpose of this SSP is to create a curriculum for child welfare stakeholders that will focus on increasing stakeholder awareness of the current state of sex education in the United States, with activities and resources that seek to increase and engage participants' knowledge of SRH, healthy relationships, and pregnancy prevention utilizing a trauma-informed perspective.

##### a) SSP Objectives

- i) Identify gaps in SRHHRE-related information and key areas of interest among child welfare systems staff and stakeholders
- ii) Use these findings to inform a [A] a curriculum designed for dependency court stakeholders and [B] Peer-to-peer SRHHRE curriculum for foster care alumni in community college settings

##### b) Curriculum Objectives

- Educate stakeholders on the present state of sex education in the United States, including [A] its relevance to the youth in their care, and [B] the effectiveness and associated outcomes of [1] abstinence-only and [2] comprehensive sex education models

- Promote accountability among stakeholders for the provision of medically accurate, comprehensive, developmentally appropriate sex education and to illustrate the unique vantage point of child welfare stakeholders to intervene in this area
- Introduce stakeholders to trauma-informed approaches to the discussion of sexual health and healthy relationships education and related topic and increase stakeholder comfort levels regarding to their ability to practice such approaches
- Increase stakeholders' self-efficacy relating to the discussion of topics related to sexual health and health relationships
- Provide stakeholders with free, accessible, and understandable resources that can be utilized to support and sustain the discussion on sexual health and healthy relationships with youth in care
  - Increase CWS stakeholders' ability to be an "askable adult"
    - Stakeholders will be able to:
      - Understand basic SRH concepts
      - Refer youth to appropriate information sources

## List of terms and abbreviations

<i>Terms</i>	<i>Definitions</i>
Dependency Courts, Child Welfare, Foster Care	These terms are used interchangeably, referring to institutions and systems involving child protective services to the degree that children are removed from the care of their biological parent(s,) involving the potential for the termination of parental rights, and placement of the youth in state care.
Youth in Care	This term refers to youth who are in the guardianship of the state, whose biological parent(s') rights may or may not have been terminated or suspended.
Systems-Involved Youth	This term encompasses youth involved in child welfare or juvenile justice systems.
Askable adult	An askable adult is a trusted figure in the lives of youth to whom they feel comfortable confiding relationship information regarding partners and SRH-related topics.

<i>Abbreviation</i>	
SRHHRE	Sexual Health, Reproductive Health, and Healthy Relationships Education
SRH	Sexual and Reproductive Health
NSSE	National Standards of Sex Education
SSP	Special Studies Project
STI	Sexually Transmitted Infection
LGBTQ	Lesbian, Gay, Bisexual, Transsexual, Questioning (including Intersex, and Asexual) Identifying-Individuals



## II. Literature Review

### 1) Trauma

Definitions of trauma often are interchangeable, referring to a series of or a singular event, the immediate resulting emotional and/or physical distress, long-term outcomes, and/or the threat of actual or perceived harm. (Development Services Group Inc, 2016) Trauma is often defined by the lived experience of the survivor, distinguished by a sensory and/or psychological experience that overwhelms one's ability to cope. Trauma can occur as a result of a natural disaster, scaled events such as war or terrorism, accidents, injury, witnessing intensely stressful or violent event, or being the victim of any type of abuse. (National Child Traumatic Stress Network, 2003) It should be noted that such events can be accompanied by severe victimization. Victimization is best defined by researcher Daniel Finkelhor:

*[V]ictimization can be defined as harm that comes to individuals because other human actors have behaved in ways that violate social norms. Even though we sometimes refer to people as "victims of hurricanes", "cancer victims", or "accident victims", the more common reference for the term victimization is interpersonal victimization. In interpersonal victimization, the elements of malevolence, betrayal, injustice, and immorality are more likely to be factors than in accidents, diseases, and natural disasters. (Finkelhor, 2008)*

Trauma, including victimization, can result in persistent and chronic altered cognitive, psychological, social, and biological functioning. (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012) The Diagnostic and Statistical Manual of Mental Disorders includes "reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders" in the context of trauma and stressor related disorders. (American Psychiatric Association & American Psychiatric Association DSM 5 Task Force, 2013) In addition to the psychological effects of trauma, it is known that trauma can also result in altered neurological development, along with other negative physical/biological

and economic outcomes. The Adverse Childhood Experiences Study is one of the largest studies to link adverse childhood experiences (ACEs) to quality of life and other outcomes. The study was originally housed and conducted at Kaiser Permanente and has since transitioned to the Centers for Disease Control and Prevention for more detailed surveillance including updates from national morbidity and mortality data. This data reports that nearly 20% of participants reported experiencing three or more ACEs, and 2/3 experiencing at least one ACE. As the number of ACEs increases so does the risk of a number of adverse outcomes such as alcoholism, smoking, sexually transmitted infections, illicit drug use, fetal death, financial stress, risk for intimate partner violence, risk for sexual violence, poor academic performance, and poor academic performance. (Centers for Disease Control and Prevention, 2016a) These outcomes only represent a portion of the possible negative outcomes and increased risks associated with ACEs and trauma. While further analysis is needed to investigate these outcomes and related interventions, it is necessary to understand traumas, youth's experience, and how trauma-informed services can negate these effects.

Complex trauma, sometimes known to as polyvictimization, refers to the occurrence of multiple/repetitive, hostile forms of trauma often of an intrapersonal nature. (Dissociation, n.d.; The National Child Traumatic Stress Network, n.d.-b) The severity of trauma is often complicated by perpetration at the hands of family and caregivers. Complex trauma is associated with impaired/negative attachment, biological, affect regulation, disassociation, behavioral control, cognition, and self-conceptualization outcomes. (Cook et al., 2017) Studies have confirmed that increased exposure to traumatic events (complex trauma) is strongly associated with an increased probability of reporting poor health, seeking mental health treatment in adulthood in some populations. (Messina & Grella, 2006) Another study by Kisiel et al., utilizing

data retrieved from the Child and Adolescent Needs and Strengths (CANS) assessment, found that:

*“with multiple and chronic caregiver-related trauma [complex trauma] exhibited more mental health needs across all domains...including significantly more traumatic stress symptoms (including typical PTSD symptoms), [and] broader emotional/behavioral needs (including depression, anxiety, and oppositional and substance use problems), more risk behaviors (including suicide, self-mutilation, aggression, and sexually reactive behaviors), and life functioning difficulties (including problems with school, peers, job, and family)...”* (Kisiel, Fehrenbach, Small, & Lyons, 2009)

While other studies support associations represented by this study and the ACE data, further research is needed to include a diversity of groups/populations and a wider variety of outcomes.

(Van der Kolk, 2017)

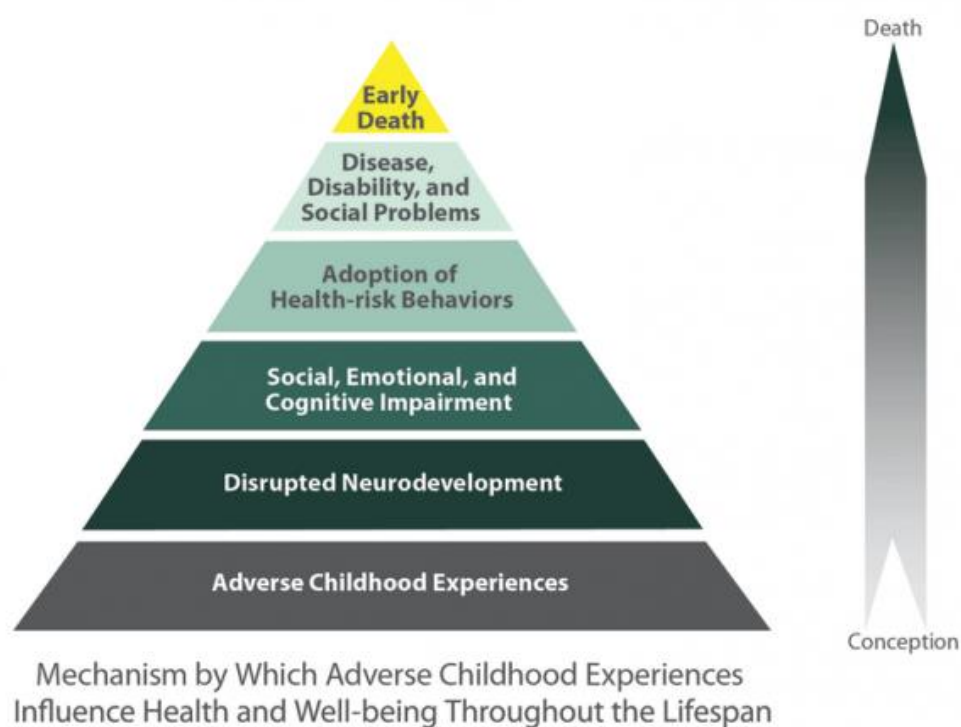


Figure 1: The ACE Pyramid

(Centers for Disease Control and Prevention, 2016b)

Manifestations of these outcomes are variable depending on the age at which the trauma(s) occur. Young children, especially those under the age of five, are particularly sensitive to disruptions in routine activities. Expression can be difficult to understand due to infant/toddlers' lack of verbal skills. Trauma at this age is often internalized in feelings of helplessness and anxiety, which can result in a plethora of adverse behavioral and neurological outcomes. (The National Child Traumatic Stress Network, n.d.-a) This can affect children's ability to develop the cognitive capacities for verbal development and emotional regulation. (Cook et al., 2017) Skills the child may have already developed, such as sleeping patterns, bowl-movement regulation, and verbal skills, can regress, which can result in impaired ability to form social connections and self-regulate. (Cook et al., 2017; The National Child Traumatic Stress Network, n.d.-a)

School-aged children (5–11 years old) with increased communication and cognition skills are often most concerned with their own actions in relationship to experiencing or witnessing a traumatic event. Children raised in secure environments are able to learn and assign complex descriptors to their emotions and experiences; without this sort of environment and positive caregiver support, children are not able to categorize or regulate their emotions and experiences. This can cause anxiety, attachment issues, and disassociation at a young age, resulting in the inability to form healthy relationships with peers and caregivers, along with the ability to appropriately articulate themselves and orient themselves to the world around them. (Van der Kolk, 2017) Common expressions of trauma at this age include sleeplessness, often marked by nightmares, as well as other physical responses such as spontaneous stomach pain, headaches, or generalized pain. Teachers often report that students at this age may exhibit aggressive behaviors, increased distraction in classroom settings, or lack of interest in peer-related social activities. (FEMA, n.d.; The National Child Traumatic Stress Network, n.d.-a)

Trauma affecting adolescents and teens (ages 12–18) often plays a crucial role in shaping youths perceptions of the world around them, including their ability to process complex events, and form healthy relationships with peers, adults, authorities, and romantic partners. Threats to personal safety or that of loved ones is internalized and can produce high levels of anxiety. This age group exhibits a keen awareness for the thoughts and feelings of their peers at this age, they are often plagued by the concern of appearing abnormal to their peers. At this time, youth can comprehend that their lived experience is divergent from their “normal” peers, and might withdraw from group settings, exhibit reckless/risk-taking, or self-destructive behaviors. (The National Child Traumatic Stress Network, n.d.-a)

Children have differential experiences of trauma given their age and exposure to traumatic events. The literature indicates that more research is needed on the outcomes of childhood exposure to trauma with attention to age and trauma exposure. The figure below illustrates a summary of immediate, intermediate, and long-term reactions to trauma common to children of all age ranges. (Kenardy, Le Brocque, March, & De Young, 2010)

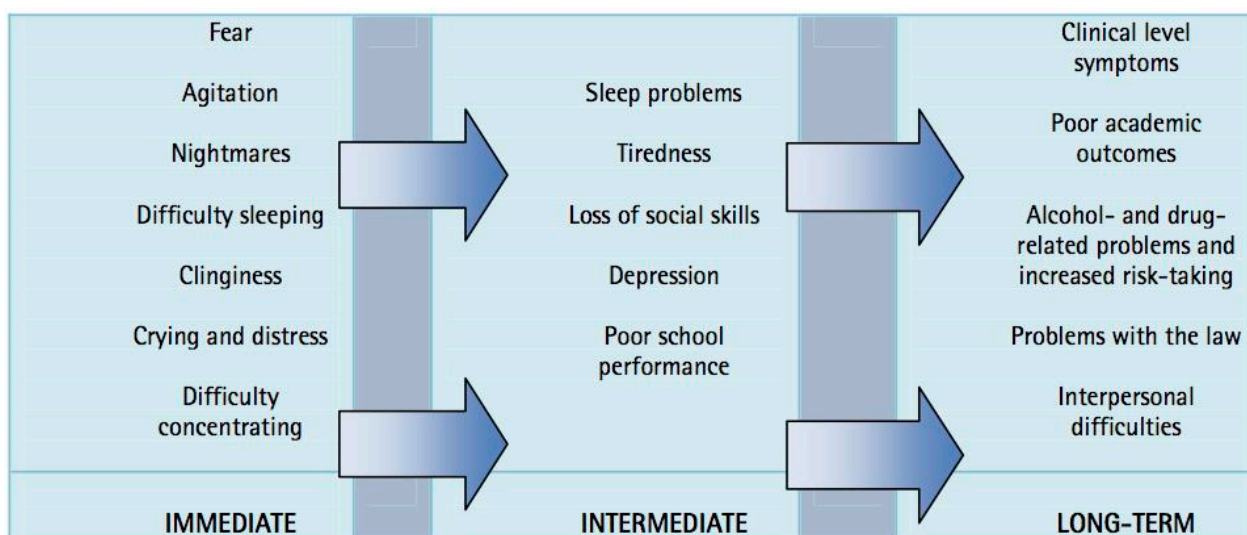


Figure 2: Symptoms of Trauma in Children/Adolescents Summary (Kenardy et al., 2010)

SRH-related trauma can also affect sexual risk behaviors and decision-making. There is a considerable amount of research available on the SRH-related outcomes and risk behaviors of survivors of sexual trauma. In 2003 it was reported that nearly 32% of females and 14% of males experience sexual abuse before the age of 18, of which almost 47% are perpetrated by family members. (Briere & Elliott, 2003) According to a 2010 report from the Centers for Disease Control and Prevention (CDC,) nearly one in five women have been raped in their lifetime, compared with one in 71 men; one in three women and one in four men will experience intimate partner violence in their lifetime. (Black et al., 2011) Awareness of the lifetime and childhood prevalence of SRH-related violence provides a clearer understanding of the state of trauma and its potential effects on adverse life outcomes. Prevalence data such as this is important for child welfare stakeholders to understand in order to be effective advocates for the youth in their care. However, it is noting that prevalence studies such as the latter and those measured by ACEs are likely skewed by underreporting.

A 2009 prospective cohort study indicated that childhood sexual and physical abuse increases individuals risk for sexually transmitted infections. (Wilson & Widom, 2009) These findings are corroborated by a 30-year longitudinal cohort study reporting that “maltreated children are more likely to report sexual contact before age 15, engage in prostitution by young adulthood, and test positive for HIV in middle adulthood.” (Wilson & Widom, 2008) Earlier (consensual) initiation of sex is associated with abuse in populations of girls; nationally, the average at first sex for non-abused populations is 16.2, while that of abused female populations is 13.8. Not only are victims of abuse more likely to engage in sexual activity at an earlier age, but studies report increased engagement with drug abuse and commercial sex work. (Wilsnack, Vogeltanz, Klassen, & Harris, 1997; Wilson & Widom, 2008) Childhood sexual abuse and

dating violence is also positively associated with STI transmission, adolescent pregnancy, and unplanned pregnancy. (Homma, Wang, Saewyc, & Kishor, 2012; Koenig, Doll, O'Leary, & Pequegnat, 2004; Miller et al., 2010; Silverman, Raj, Mucci, & Hathaway, 2001) Victims of childhood sexual abuse are nearly twice as likely to become pregnant before the age of 18. (Noll, Shenk, & Putnam, 2009) In a study of adolescent girls who experienced dating violence, nearly 25% reported their partner expressing a desire to impregnate them. (Lanier, Moldovan, & Priddy, 2014) Additional impacts of trauma on sexual development also include: early onset puberty, sexual dysfunction, victimization, sexual identity confusion, compulsive or indiscriminate sex, relationship difficulties, body image concerns, negative associations with sex, and sexually abusive behavior. (Brown, 2014) Given this strong correlative data, it is imperative that sexual health utilize a trauma-informed approach to intervene and prevent victimization and adverse outcomes for youth in care.

## **2) Resilience**

The American Psychological Association defines resilience as the “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress.” (American Psychological Association, 2014) However, many experts have noted that this definition does not fully encompass the complexity of resilience. (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014) Research documents that resilience is correlative to development and may change over time. (Kim-Cohen & Turkewitz, 2012) Among current literature, it is reported that resilience among victims of childhood trauma is low. A 2000 study measured that only 22% of childhood victims of abuse and/or neglect had achieved resiliency based on an assessment of healthy adult functioning. (McGloin & Widom, 2001)

Some researchers have identified modifiable resilience factors that can positively influence youth's immediate and long-term health outcomes. These factors include: "fostering positive appraisal styles in children and bolstering executive function, improving parenting, supporting maternal mental health, teaching parents the importance of good self-care skills and consistent household routines, and offering anticipatory guidance about the impact of trauma on children." (Traub & Boynton-Jarrett, 2017) Individual resilient characteristics include self-regulatory techniques, including the ability to regulate emotions and experiences, such as placing blame and processing emotions, optimism, perseverance after adverse events, social competence and the courage to persist in the face of fear. (Cicchetti & Rogosch, 2009; Collishaw et al., 2007; Traub & Boynton-Jarrett, 2017; Wrenn et al., 2011)

Research focusing on the complexities of trauma among youth in the child welfare system is minimal. However, Griffen et al. utilized the CANS assessment to measure traumatic experiences, risk behaviors, and strengths in 8,131 children using logistic regression models. The study found that individuals entering the child welfare system were impacted by complex traumas strongly correlated with high risk behaviors, corroborating the widely cited 1998 research utilizing ACEs data to associate complex trauma with risk behaviors and early mortality. (Felitti et al., 1998) However, more strengths were associated with fewer risk behaviors – that is to say, youth displaying increased development of personal strengths were less likely to engage in risky behaviors. (Griffin, Martinovich, Gawron, & Lyons, 2009) While this study does not speak directly to trauma-informed care, it does illustrate that increased development of personal strengths, drawing on many of the aforementioned principles, could negate youth's experience with risk behaviors.



A similar study, utilizing a sample of 4,272 youths between the ages of 0-18 entering the child welfare system measured by the CANS survey reported that children with caregiver-related trauma exhibited more risk behaviors, life-functioning difficulties, and fewer overall strengths. (Kisiel et al., 2009) Perhaps, it is not surprising that children in foster care exhibit fewer strengths than their peers. Separation from biological family members, often compounded by geographical distance, creates stress and surrounds youth with a lack of social support that many of their peers take for granted. The *Academy of Management* defines social capital as:

*“the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit. Social capital thus comprises both the network and the assets that may be mobilized through that network”*(Nahapiet & Ghoshal, 2000)

Researches have positively associated increased social capital to children’s and adults well-being.(Kunitz, 2004; Runyan et al., 1998) Internalization of this stress and lack of support can lead to further social isolation among peers. Youth in care are often not presented with the equitable resources to their peers barring them from “normal” social activity and connections, such as regular participation in extracurricular or community-based activities.

Research is limited in this area being that few longitudinal studies are available on resilience in children who have experienced trauma in their lifetime. (Traub & Boynton-Jarrett, 2017) Limitations to resilience include the discussion of resilience as an adaptable universal quality, rather than an individual characteristic; and an expectation of resilience in the face of adversity and trauma among youth and adults. It is important for research to specify whether resilience is being operationalized as a trait, a process, or an outcome. (Southwick et al., 2014) Research focused on youth involved in the child welfare system is limited and should be

expanded to include resiliency and modifiable factors that can be adapted in group-home and in-home settings.

### **3) Trauma-Informed Care**

Trauma-informed care is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as:

*“A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”* (Substance Abuse and Mental Health Services Administration, 2014)

Trauma-informed care and trauma-informed approaches are critical to programs that unite behind the common purpose of avoiding re-traumatization, building resilience, and giving youth the tools to regulate their emotions in order to become functioning adults. In the context of professional relationships with youth, professionals advocate that such systems (trauma-informed services) should be implemented in mental health, juvenile justice, child protective, and educational settings. (Hodas, 2006)

Many organizations that provide these services (without a trauma-informed approach) utilize practices and create stress that risks re-traumatizing individuals. (Dekel, Ein-Dor, & Solomon, 2012; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005) SAMHSA and other institutions offer guiding principles that can be utilized in order to create trauma-informed environments. These principles have been identified through empirical and qualitative research. The model that SAMHSA espouses focuses on six generalizable principles that may be scalable to any agency, rather than focusing on a unique set of practices. This model was informed by systems currently operating under principles that are not best suited to the needs of traumatized

individuals, exploring research and methods to overcome structural barriers to trauma-informed care. In order to improve systems, organizations should operate under principles of safety, trustworthiness, transparency, collaboration, and empowerment. This should also be inclusive of peer support models that account for cultural, historical, and gender issues/complexities.

(Substance Abuse and Mental Health Services Administration, 2014)

Denise E. Elliott et al.'s principles for trauma-informed care for services specific to women utilize the works of known trauma-informed care researchers Maxine Harris and Richard Falloot. However, this is unique, due to the diversity of service sites sampled to inform their recommendations. According to these principles trauma-informed approaches to women's services should recognize the impact of violence and victimization on development and coping strategies; identify recovery from trauma and minimize retraumatization as primary goals employ an empowerment model, strive to maximize [a woman's] choices and control over [her] recovery, based in a relational collaboration among stakeholders and solicit consumer input and involve consumers in designing and evaluating services, create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance, emphasize women's strengths, highlighting adaptations over symptoms and resilience over pathology, strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background. (Elliott et al., 2005)

The Chadwick Center for Children and Families and other researchers note that even though child welfare stakeholders and social service staff may be well-trained in evidence-based programs to treat youth, many are unaware of trauma-informed methodologies. (Chadwick Center for Children and Families, 2009; Chaffin & Friedrich, 2004) The National Child Traumatic Stress Network designed the *Child Welfare Trauma Training Toolkit* in collaboration

with several organizations focusing on mental and physical health in the context of seeking permanency and well-being for children. This toolkit offers stakeholders tools and strategies for interacting with youth with a history of complex trauma that they may or may not be aware of as stakeholders. Organizations fitting such descriptions should strive to comply with the following guidelines in order to create positive environments for youth in care: maximize the child's perception of safety, assist children in reducing overwhelming emotion, help children make new meaning of their trauma history and subsequent experiences, address the impact of trauma and subsequent changes in the child's behavior, development, and relationships, coordinate services with other agencies, utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services, support and promote positive and stable relationships in the life of the child, provide and support guidance to the child's family and caregivers, and manage professional and personal stress. (Child Welfare Committee & National Child Traumatic Stress Network, 2008)

#### **4) Trauma-Informed SRHHRE**

Research-based and evidence-based trauma-informed comprehensive SRHHRE curricula are scarce, if not virtually unavailable. There are a few resources available that provide guidelines on how to adapt existing evidence-based, evaluated sex education curricula utilizing a trauma-informed approach. Lanier et al, with the Colorado Coalition Against Sexual Assault, collaborated to respond to the needs of “Colorado Personal Responsibility Education Program (PREP) regarding...[an] effective response to and engagement of PREP participants who have experienced, or are currently experiencing trauma.” (Lanier et al., 2014) This guide reviews evidence-based curricula such as: *Be Proud! Be Responsible!*; *Cuidate*; *Draw the Line, Respect the Line*; and *Street Smart*, and provides trauma-informed care “notes” throughout the curricula

so that facilitators can easily adapt existing curricula. The authors recognize the potential impacts of trauma on sexual beliefs, aligning their recommendations on the belief “that behaviors and responses that may seem ineffective and unhealthy can represent adaptive responses to past traumatic experiences.” (Lanier et al., 2014) This is valuable because many of these curricula are widely implemented across the United States and speak to a diverse range of populations.

More resources exist concerning the principles of a trauma-informed sex education curriculum and the importance of a trauma-informed approach to sex education, not only for vulnerable populations, but also for generalized populations of youth. (Schergen & Hebert, 2016; Schladale, 2013) In coordination with Resources for Resolving Violence, Inc. Joann Schladale developed *A Trauma-informed Approach for Adolescent Sexual Health*. The author defines a trauma-informed approach for adolescent sexual health as:

*“a way of addressing vital information about sexuality and well-being for teens that takes into consideration adverse life experiences and their potential influence on sexual decision making. The goal of such an approach is to prevent sexual harm, unplanned and unwanted pregnancy, and/or disease.”* (Schladale, 2013)

This toolkit provides an overview of sex education with attention to vulnerable populations, including youth in foster care, youth with disabilities, pregnant and parenting teens, and more. Schladale develops this overview with regard to primary, secondary, and tertiary prevention strategies utilizing a trauma-informed approach with evidence informed strategies for educational and therapeutic services. (Schladale, 2013)

The principles of trauma-informed education, as mentioned above, can be utilized to create a framework for trauma-informed SRHHRE. Schergen & Hebert adapted SAMHSA’s six principles of trauma-informed care to provide guidelines regarding how providers and educators can increase their awareness of traumatic experiences among youth and how this affects their ability to fully comprehend SRHHRE. This guide is an excellent resource for anyone

implementing an evidence-based intervention for young adults. It provides helpful strategies such as how to use inclusive language with teens, reshaping traditionally shameful language around sex, dealing with triggers, and disclosure as a professional. (Schergen & Hebert, 2016) It is incredibly valuable for professionals to recognize and reshape traditionally shameful messages about sex. This is especially important for teens who may have experienced a form of sexual abuse outside of their control. See example below:

<b>Common Shaming Messages</b>	<b>Possible Re-Frame</b>	<b>Rationale</b>
Most teen moms end up living in poverty	Raising a child is hard work and costs money; many parents find they need to sacrifice a lot in order to provide for their family. Think about your goals and dreams and about how having a child would fit into your plans. What are you willing or unwilling to sacrifice?	Removes stigma from pregnant or parenting teens
Don't be embarrassed to buy condoms; pregnancy or an STI are even more embarrassing!	It is important to work through feeling embarrassed about buying condoms; it is the responsible thing to do to protect yourself and your partner.	Removes element of shame from unintended pregnancy and STIs
Experimenting with sex to satisfy curiosity is unhealthy	Feeling curious about sex is something many young people go through as they become adults. If you are going to have sex, protect yourself! Use condoms and other barriers, and make sure you can communicate effectively with your partner(s).	Removes judgement/shame
You shouldn't have sex with someone you don't know very well	It's important to talk honestly and openly about safer sex with all of your partner(s).	Removes judgment/shame

*Figure 3: Reframing Shaming Messages in Sex Education (Schergen & Hebert, 2016)*

Common shaming messages, such as those mentioned above, are prominent among peer groups and may be reflected in health education curricula. It is important that educators and stakeholders are not only trained and aware of the effects of shameful messaging, but also able

to advocate for youth and reframe messaging to create a positive, trauma-informed encounter for youth.

### **5) SRH-Related Outcomes Among Youth in Care**

The research on pregnancy and SRH-related outcomes among youth in foster care is extremely scarce. The most recent data on this subject is informed by a representative sample of youth in foster care at age 19 from the state of California based on the findings from the California Youth Transitions to Adulthood Study (CalYOUTH). This study reports that 17% of youth experience their first sexual intercourse between 10 and 12 years old. Nearly one in three respondents reported using no form of birth control or condom during sexual encounters in the previous year. 5.7% of youth reported ever having sex with someone that paid them to do so, and among those respondents more than half went on to report that this happened on more than one occasion. Nearly half of female respondents have been pregnant, and a fourth of male respondents reported they had “gotten [a] female pregnant.” One in four females progressed to give birth to a child. The majority of respondents did not want to be pregnant at the time, and 12.8% did not receive any prenatal care. 20% of respondents already had a child at the time of the survey. (Courtney et al., 2016) While this data is limited by its restriction to youth in California, it is valuable in the attempt to understand youth in care’s risk factors and susceptibility to pregnancy and other adverse SRH-related outcomes such as relationship abuse, STI transmission, and related mental health issues.

The only other widely-cited source of data on pregnancy outcomes among youth in care is the *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19*. While dated to 2005, this data is widely cited in order to illustrate the urgency of pregnancy prevention measures and increased access to services for youth in care. This study reports that

compared to their peers not in state care, youth in care are 2.5 times more likely to become pregnant; one third of females in foster care will become pregnant before the age of 17, increasing to half of all females by age 19. (Courtney et al., 2005) This is complicated by the fact that nearly 50% of youth will have a subsequent pregnancy before the age of 19. (Bilaver & Courtney, 2006)

These outcomes are complicated by the fact that there is an association between placement in the child welfare system and transactional sex and human trafficking. (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Speckman, 2015) Involvement in transactional sexual encounters and human trafficking leads to a host of other negative outcomes, aside from unplanned/unwanted pregnancy, that further inhibit youth in care from at minimum attaining functional autonomy, along with other positive outcomes such as educational attainment, economic independence, and emotional self-regulation. It is important that child welfare staff and stakeholders are aware of this association, not only to increase the prevalence of trauma-informed approaches to care, but also to identify possible routes to prevention and intervention. This is also significant because the child welfare system has historically not been held accountable for producing young adults that do not have the mental or physical capacity to function in society as autonomous adults without familial support.

#### **6) Sex Education in the United States**

Youth's receipt of sex education in the United States is completely variable on state and local policies. Only 24 states and the District of Columbia mandate sex education to be taught in public schools. Medically accurate, comprehensive sex education is not mandated in all 50 states, medically accurate information is only mandated in 13 states. Local preferences dictate how and if sex education is delivered in school settings. In total, 12 states require sex education to include



discussions on sexual identity and orientation; three states require only negative information on sexual orientation. (Guttmacher Institute, 2018)

While every model is slightly variable, abstinence-only education models tend to focus on heteronormative relationships, and the consequences of sexual activity, often portrayed with negative connotations, generally ignoring the complexity of sexual relationships, reproductive health, and healthy relationships. In such models, youth are encouraged to seek sexual engagement within the context of a marriage. Revised in 1996, Title V of the Social Security Act (Sec. 510. [42 U.S.C. 710]) specified eight principles for abstinence-only education models (see figure below) that – if followed, states could receive federal funding, totaling nearly \$85 million in 2016. According to these guidelines, abstinence-only education should promote that “sexual activity [and bearing children] outside of the context of marriage is likely to have harmful psychological and physical effects.” Currently, 37 states require that information on abstinence be presented, 26 require that it should be stressed. (Guttmacher Institute, 2018) However, even with these guiding principles, communities receiving funding are still allowed control over curriculum development and implementation locally. (Boonstra, 2009)

## ABSTINENCE VS. SEX EDUCATION

### **Abstinence-only Education, as Defined by Current Federal Law**

According to Title V of the Social Security Act, an eligible abstinence education program is a program that

- A)** has as its exclusive purpose, teaching the social, physiological, and health gains to be realized by abstaining from sexual activity;
- B)** teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;
- C)** teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- D)** teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
- E)** teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- F)** teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- G)** teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- H)** teaches the importance of attaining self-sufficiency before engaging in sexual activity.

### **Sex Education, as Defined by the Responsible Education About Life Act**

According to the Responsible Education About Life Act, a sex education program is a program that

- (1)** is age-appropriate and medically accurate;
- (2)** stresses the value of abstinence while not ignoring those young people who have had or are having sexual intercourse;
- (3)** provides information about the health benefits and side effects of all contraceptive and barrier methods used—
  - (a)** as a means to prevent pregnancy; and
  - (b)** to reduce the risk of contracting sexually transmitted disease, including HIV/AIDS;
- (4)** encourages family communication between parent and child about sexuality;
- (5)** teaches young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances and how to avoid making verbal, physical, and sexual advances that are not wanted by the other party;
- (6)** develops healthy relationships, including the prevention of dating and sexual violence;
- (7)** teaches young people how alcohol and drug use can affect responsible decision making; and
- (8)** does not teach or promote religion.

Figure 4: Abstinence vs. Sex Education Courtesy of the Guttmacher Institute (Boonstra, 2009)

Conversely, in 2009, the Responsible Education About Life Act was introduced to Congress in order to promote enhanced SRHRE to American youth. Other guidelines have been released by third-party agencies, such as the Future of Sex Education, that provide guidelines as to what should be included in any educational models that deem themselves “comprehensive.” Adapted from CDC guidelines on health education, the Future of Sex states that comprehensive sex education should include:

*“A planned, sequential K-12 curriculum... [that] addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality. The curriculum should be designed to motivate and assist students to maintain and improve their sexual health, prevent*

*disease and reduce sexual health-related risk behaviors. It should allow students to develop and demonstrate developmentally appropriate sexual health-related knowledge, attitudes, skills, and practices. The comprehensive sexuality education curriculum should include a variety of topics including anatomy, physiology, families, personal safety, healthy relationships, pregnancy and birth, sexually transmitted diseases including HIV, contraceptives, sexual orientation, pregnancy options, media literacy and more. It should be medically accurate. Qualified, trained teachers should provide sexuality education.”* (Future of Sex Education, n.d. )

Currently, Oregon is the only state that legally mandates uniform sex education standards in all public primary and secondary schools. This includes criteria specifying that each school district must provide medically accurate, comprehensive sex education. Under this regulation, schools are still required to not only present, but also promote abstinence. (ORS 336.455) This is successful to the degree that abstinence is the only 100% effective way to prevent pregnancy and sexually transmitted infections. There are many evidence-based programs focusing on abstinence and sex education that have been rigorously evaluated by the Office of Adolescent Health (OAH). OAH accounts for outcomes such as sexual debut, number of sexual partners, frequency of sexual activity, use of contraceptives, pregnancy, birth, and sexually transmitted infection status.

Without adherence to uniform curriculum or implementation guidelines, it is unlikely that youth will graduate high school or enter adulthood with equitable amounts of knowledge about their own sexual or reproductive functioning, healthy relationships, or sexuality. Many studies have looked to quantify the consequences of abstinence-only and sexual education programs in order to advocate for more inclusive models that adequately prepare youth for adulthood and sexual responsibility. Several proponents of abstinence-only programs operate on a fear that topics related to sex, such as contraception, would encourage youth to initiate and sustain sexual activity. A study published in the *Journal of Adolescent Health* found that educating youth with comprehensive sex education did not increase their risk of sexual activity or STI transmission.

The study also reported that youth who received comprehensive sex education compared to youth who received no formal sex education or abstinence-only programming were less likely to become pregnant. (Kohler, Manhart, & Lafferty, 2008) Stanger-Hall found that abstinence-only programs may in fact contribute to the rise in teen pregnancy rates. (Stanger-Hall & Hall, 2011) Grossman et al. determined the effectiveness of delaying vaginal sex for a cohort of middle school students followed for three years, N= 2,453. This study reported that in schools with “theory-based, developmentally appropriate, comprehensive sex education” 16% less male students and 15% less females initiated sex by the end of eighth grade compared to the schools in which the program was not delivered. (Grossman, Tracy, Charmaraman, Ceder, & Erkut, 2014) A review of 56 studies analyzing the effects of abstinence-only and comprehensive sex/HIV education found that two-thirds of comprehensive programs had positive effects on youths behaviors including delayed sexual initiation and increased condom use. (D. B. Kirby, 2008)

### **7) Protective Factors Against Teen Pregnancy**

Data from the National Center for Health Statistics reports nearly half of all unmarried 15-19 year olds have ever had sexual intercourse. (Martinez & Abma, 2015) There are a number of discrete decisions impacting teens’ decision to have sex, as well as their perceived facilitators/barriers to contraception use. (Berry, Shillington, Peak, & Hohman, 2000; East, Khoo, & Reyes, 2006; D. Kirby & Lepore, 2007) Many of these factors inform evidence-based SRHHRE curricula that focus on pregnancy prevention. However, youth in care are often disadvantaged due to the variable state of sex education availability and reliability in the United States, and their inconsistent access to resources and support. The following illustrates a brief discussion of protective factors against teen pregnancy, colored by foster youths’ barriers to

typical supports and interventions, with attention to which protective factors that can be facilitated in the lives of foster youth.

Given foster youth's lack of consistent access to familial and social supports, many protective factors against teen pregnancy are virtually unavailable to this entire population. As previously mentioned, researchers have been able to identify which factors serve as a deterrent to sexual debut and teen pregnancy. Kirby et al. report the following factors have the potential to protect youth from pregnancy and STI transmission:

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Strong parental relationships, including conversations regarding sexual health, sexuality, and contraceptive options</li> <li>• Parental support of contraception, especially in regard to its uptake among sexually active teens</li> <li>• Parental disapproval of premarital sex</li> </ul> | <ul style="list-style-type: none"> <li>• Increased parental monitoring/supervision</li> <li>• Religious affiliations</li> <li>• Increased cognitive development</li> <li>• Older age at voluntary first sex</li> <li>• Increased academic and community involvement (D. Kirby &amp; Lepore, 2007)</li> </ul> |
|---|--|

These factors can be difficult to facilitate in the lives of youth involved in the child welfare system. These youth have low to virtually nonexistent parental support structures, being that they have been removed from the care of their biological family. This places youth at a disadvantage because trusted adult figures are not readily available to support youth and engage in relationships that could sustain conversations about SRH in order to protect youth against teen pregnancy and STI transmission. Lack of parental support, along with the transient nature of foster care and group home placements, leads to lack of academic, social, and community networks. As previously discussed, youth in foster care are also likely to have experienced some form physical, emotional, sexual and/or psychological trauma that can lead to developmental delays affecting emotional regulation and decision-making skills. (Cook et al., 2017) Other

consequences of trauma, such as depression, are also linked to increased risk of teen and unplanned pregnancy. (D. Kirby & Lepore, 2007) Effective interventions should focus on factors below that Kirby et al. identify that are more malleable than those mentioned above:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Peer and partner use of condoms</li> <li>• Increased educational aspirations</li> <li>• Increased academic and community involvement</li> <li>• Increased perceptions of male responsibility in efforts to prevent STI transmission and pregnancy</li> <li>• Decreased barriers to condom access</li> </ul> | <ul style="list-style-type: none"> <li>• Discussing pregnancy and STI prevention with peers and partners</li> <li>• Positive attitudes towards contraception</li> <li>• Increased access to team sports (females only) (D. Kirby &amp; Lepore, 2007)</li> </ul> |
|--|---|

Many evidence-based, medically accurate, comprehensive SRHHRE curricula can facilitate the promotion of protective factors such as those mentioned above. These factors can also be facilitated by institutional support of youth involvement in academics and extracurricular activities. Child welfare stakeholders can increase placement accountability and training in topics related to SRH for stakeholders and staff to convey the urgency of the cultivation of positive support networks, trusted adult relationships, and SRHHRE.

### III. Methods & Survey Results

#### 1) Curriculum Context

Prior to the development of this curriculum surveys were administered by convenience sampling at nine training sites selected by Power to Decide for the 2017-2018 cycle of the Training and Technical Assistance Project: Addressing Teen and Unplanned Pregnancy in Dependency and Juvenile Justice Courts. The Training and Technical Assistance Project includes a four-hour training: *“When You Decide...” A Judge’s Guide to Pregnancy Prevention Among Foster Youth with Bench Tools & Scripts (“When You Decide,”)* including stakeholder-led action planning, followed by a year of technical assistance. Surveys included questions asking respondents what topics they would like to see included for training expansion. Topics for training expansion included: human trafficking, LGBTQ youth engagement, and trauma-informed SRHHRE. Two additional short answer questions were also included in the survey:

- a) What would you like to know about SRH (sexual and reproductive health) in relationships to your first preference?
- b) What basic information regarding SRH and relationships would you like to receive in future training materials?

Respondents were prompted to rank which topics they preferred (first, second, and third choice) to receive additional training and resources. The curriculum focus was shaped around the topic that a majority of participants indicated as their first choice for a curriculum supplement.

Participants also had the option to provide their contact information. Participant responses were recorded on paper, digitally transcribed and analyzed using Google software.

## 2) Survey Results

A total of 194 respondents answered at least one question on the survey. 97% of respondents indicated a first-choice for training expansion, n=189, of which 39.7% of respondents reported that trauma-informed SRHHRE was their first preference for expanding training materials and stakeholder tools; 39.2% indicated human trafficking, and 21.2% indicated LGBTQ youth engagement. 86% of respondents indicated a second-choice, n=167; 27.5% of respondents reported that trauma-informed SRHHRE was their second preference for expanding training materials and stakeholder tools; 34.7% indicated human trafficking, 37.7% indicated LGBTQ youth engagement. 84% of respondents indicated a third-choice, n=164; 34.4% of respondents reported that trauma-informed SRHHRE was their third preference for expanding training materials and stakeholder tools; 25.8% indicated human trafficking, 39.9% indicated LGBTQ youth engagement. LGBTQ youth engagement was the least preferred first choice, a majority of respondents indicated this as their second (38%) and third preference (40%.) See Figure 5 for combined results, percentages were rounded to the nearest whole number.

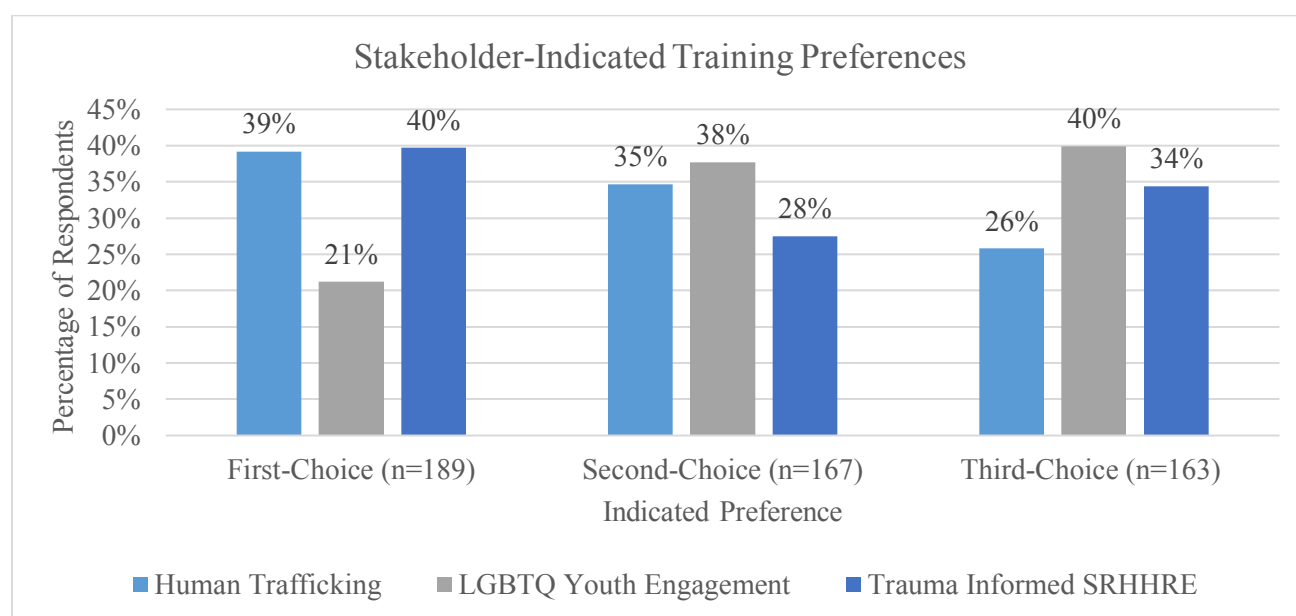


Figure 5: Dependency Court Stakeholder-Indicated Training Preferences



Responses overall indicated a desire for increased training on a diversity of topics related to each option for training expansion. Participants expressed a lack of comfort in discussing SRH-related topics with youth for fear that they might offend or trigger the youth, indicating that they would like to learn more about: “how to talk about issues while avoiding triggers that would cause emotional distress,” “how trauma affects thinking, [and the] decision making process of youth,” and “...how can we work with victimized youth to educate them without traumatizing them.” Respondents also expressed that they needed resources regarding “conversation prompts,” “websites and resources to give the youth” and many responses reflected a singular response indicating questions that stakeholders would like more information on: “what factors contribute to a teenager/preteens desire to have sexual relationships? how can we refocus youth to desire things other than having sex? how do we help youth prevent a second pregnancy?”

### 3) Curriculum Overview

This curriculum (see appendix) is stratified by three modules, [1] Sex Education in the United States, [2] Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible? and [3] Sexual and Reproductive Health Resource Overview. Within each module there is an activity and/or opportunity for content exploration (see figure 6, below.) Activities are designed to engage learners in a dynamic way in which they will be encouraged to utilize their personal and professional expertise to inform the instruction of the curriculum. Content exploration is designed for the facilitator to engage the audience in content specific knowledge utilizing a conversational/discussion-based format with the support of information provided in the accompanying presentation.

Each module is separated by individual boxes. Each module includes a summary, objectives, necessary materials, suggested time, and relevant facilitator notes. Some modules include a

suggested facilitator script. This is meant to be adapted for individual audiences and localities at the discretion of the facilitator. Any supplementary graphics are included directly following the module to which it is relevant.

<b>Module</b>	<b>Summary</b>	<b>Objective</b>
<b>Sex Education in the United States</b>	<p>This module will provide an overview of historical and current sex education policies and how localities implement sexual health curricula in public school settings. This will include information on abstinence-only and comprehensive sexual health education models, along with their associated outcomes.</p>	<ul style="list-style-type: none"> <li>• Educate stakeholders on the present state of sex education in the United States, including [A] its relevance to the youth in their care, and [B] the effectiveness and associated outcomes of abstinence-only and comprehensive sex education models; and [C] an overview of what the youth in their care/clients might be exposed to in typical American middle and/or high school educational settings</li> </ul>
<b>Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible?</b>	<p>This module will introduce stakeholders to their role as a potential trusted adult, caregiver, and/or extension of state care in the provision of developmentally appropriate, and comprehensive sex education. Additionally, this module will review tools and techniques that stakeholders can utilize in their practice directly with youth or indirectly with the other systems that youth interact with, i.e. educational and medical institutions to ensure that SRHHRE is provided in a</p>	<ul style="list-style-type: none"> <li>• Promote accountability among stakeholders for the provision of medically accurate, comprehensive, developmentally appropriate sex education and to illustrate the unique vantage point of child welfare stakeholders to intervene in this area</li> <li>• Introduce stakeholders to trauma-informed approaches to the discussion of sexual health and healthy relationships education and related topic and increase stakeholder comfort levels regarding</li> </ul>

	trauma-informed manner that best suits the needs of youth in care.	to their ability to practice such approaches
<b>Sexual and Reproductive Health Resource Overview</b>	This module will provide an overview of online and print resources that stakeholders can utilize to create trauma-informed relationships and provide appropriate SRHHRE resources to youth.	<ul style="list-style-type: none"> <li>• Increase stakeholders' self-efficacy relating to the discussion of topics related to sexual health and health relationships</li> <li>• Provide stakeholders with free, accessible, and understandable resources that can be utilized to support and sustain the discussion on sexual health and healthy relationships with youth in care</li> </ul>

*Figure 6: Curriculum Module Summary*

#### IV. Discussion, Recommendations, & Conclusions

##### 1) Discussion

##### ***Survey & Training Results***

The topic of trauma-informed SRHHRE as the focus the curriculum development was chosen as a result of preliminary survey data and generative themes from training discussions and activities. This decision was made prior to the completion of the survey for logistical reasons. The majority of participants ~ 40% (39.7%) indicated trauma-informed SRHHRE as their first choice as a topic in which to receive additional training and resources. However, there was a high degree of variability in all response categories, indicating that stakeholders involved in dependency court systems are in need of increased training across topics related to SRH.

Throughout “*When You Decide...*” trainings, participants consistently expressed a need for continuing education with specific attention to conversational tools that could be utilized with youth in care. Many times, stakeholders cited a lack of knowledge regarding local policies and procedures and an overwhelming fear that they might in some way come to harm the youth by initiating a conversation on SRH-related topics. Stakeholders feared that there were policies that in some way prohibited them from discussing these topics. These attitudes were often presented, although not exclusively, in conservative-leaning jurisdictions that did not openly support or distinctly disallow stakeholder-led discussions on pregnancy prevention and sex education. Additionally, stakeholders commonly cited a fear unintentionally harming the youth. This was exemplified by a series of stakeholders who referred to a fear of triggering youth who had been exposed to sexual trauma or accidentally relaying incorrect information. Stakeholders commonly reported that they were not aware of ways to incorporate a trauma-informed

approach in their role to SRH-related topics and events, such as medical appointments and classroom activities.

### ***LGBTQ Youth Engagement & Human Trafficking***

Stakeholders also indicated that they were not aware of how to use LGBTQ-inclusive language with their clients, and, again, were afraid that they might offend them. This often led to a report of neglecting to have discussions with youth or other stakeholders about the provision of appropriate education and services. Stakeholders across jurisdictions maintained that they had received some training including topics related to human trafficking. However, due to the lack of empirical/peer-reviewed evidence citing the link between children involved in child welfare and human trafficking, information is rarely circulated on this topic. However, stakeholders relied on a plethora of anecdotal evidence to support this connection. They expressed that while they had received some court-sponsored training on human trafficking, they were interested to learn more about how to discuss sexual health with survivors.

### ***Additional Resources***

As a result of this training, at the request of a funder, Power to Decide initiated a SRH-focused peer education program (see appendix) designed for foster care alumni and youth in extended foster care placement attending community colleges in New York, NY and Los Angeles, CA. This curriculum seeks to increase learners' self-efficacy regarding initiating and maintaining sex-positive, inclusive conversations centering on healthy relationships in the context of consensual interactions, STI knowledge, and pregnancy prevention.

### ***Strengths & Limitations***

The greatest strength of this curriculum is its novelty as a resource for dependency court stakeholders. Additionally, this training can be executed with minimal supplies and reliance on

presentation media. This training also provides concrete resources and tactics that a variety of stakeholders can utilize within their individual roles in the child welfare system within a timeframe that does not intrude on their professional routine.

The greatest limitation of this curriculum is that the time for each module is severely limited by the amount of time court stakeholders are able to dedicate to continuing education. This training could easily be expanded to include additional topics and resources; however, dependency court stakeholders have limited time and are often burdened with excessive caseloads. Additionally, there was no capacity to pilot test this curriculum barring any opportunity to further refine this project.

## 2) Recommendations & Conclusions

Further research is needed to understand and quantify the needs of youth in care. The need for national data is urgent, estimates regarding the SRH health status and outcomes of youth in care are virtually unknown at this level. However, it is known that youth in foster care are at increased risk for teen and unplanned pregnancy. (Courtney, Terao, & Bost, 2004) These youth are also consistently exposed to violence and continually exhibit poor health outcomes. The systems that involve themselves in the state-bound care of youth need to be held accountable for the deficit in positive educational and economic outcomes among foster care alumni and for improving the systems and programs that youth are exposed to during their time in care. Access to appropriate and comprehensive SRHHRE knowledge and services allows individuals to control their reproductive abilities and sexual health, which has implications for increased opportunities to pursue educational and economic advancements. These measures are largely dependent upon the improvement of foster care placements, including group home, therapeutic, and family settings. If placements and other stakeholders, such as, therapists, social workers,

CASAs, guardian ad litem, etc., are educated and made aware of the SRH needs of youth in care they can act as advocates and negotiators for youth's access to SRHHRE knowledge and services.

The provision of continuing education for dependency court stakeholders focusing on trauma-informed SRHHRE is imperative to improving the health and independent living outcomes of youth in care. Stakeholders maintain responsibility on behalf of the state for preparing youth in foster care to live independently at the age of 18 with skills and tools for personal, social, economic, and professional success. Stakeholders are not solely responsible for initiating conversations on SRH-related topics, but often provide a consistent source of resource sharing and rapport with youth and should be held accountable for ensuring that youth receive the best possible care. This care should include education and services that give youth the tools to be sexually autonomous and decide when and under what conditions to become pregnant.

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**APPENDIX**



# **TRAUMA-INFORMED SEX EDUCATION FOR YOUTH IN CHILD WELFARE:**

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**WHAT IS IT,  
WHY IT MATTERS &  
WHO IS RESPONSIBLE ?**

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**A Training for Dependency  
Court Stakeholders**

**BY : SARAH ASHLEY JOLLY**

Training Overview:

Module	Summary	Objective(s)
<p><b>Sex Education in the United States</b></p>	<p>This module will provide an overview of historical and current sex education policies and how localities implement sexual health curricula in public school settings. This will include information on abstinence-only and comprehensive sexual health education models, along with their associated outcomes.</p>	<ul style="list-style-type: none"> <li>• Educate stakeholders on the present state of sex education in the United States, including [A] its relevance to the youth in their care, and [B] the effectiveness and associated outcomes of abstinence-only and comprehensive sex education models; and [C] an overview of what the youth in their care/clients might be exposed to in typical American middle and/or high school educational settings</li> </ul>
<p><b>Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible?</b></p>	<p>This module will introduce stakeholders to their role as a potential trusted adult, caregiver, and/or extension of state care in the provision of developmentally appropriate, and comprehensive sex education. Additionally, this module will review tools and techniques that stakeholders can utilize in their practice directly with youth or indirectly with the other systems that youth interact with, i.e. educational and medical institutions to ensure that SRHHRE is provided in a trauma-informed manner that best suits the needs of youth in care.</p>	<ul style="list-style-type: none"> <li>• Promote accountability among stakeholders for the provision of medically accurate, comprehensive, developmentally appropriate sex education and to illustrate the unique vantage point of child welfare stakeholders to intervene in this area</li> <li>• Introduce stakeholders to trauma-informed approaches to the discussion of sexual health and healthy relationships education and related topic and increase stakeholder comfort levels regarding to their ability to practice such approaches</li> </ul>
<p><b>Sexual and Reproductive Health Resource Overview</b></p>	<p>This module will provide an overview of online and print resources that stakeholders can utilize to create trauma-informed relationships and provide appropriate SRHHRE resources to youth.</p>	<ul style="list-style-type: none"> <li>• Increase stakeholders' self-efficacy relating to the discussion of topics related to sexual health and health relationships</li> <li>• Provide stakeholders with free, accessible, and</li> </ul>



understandable resources that can be utilized to support and sustain the discussion on sexual health and healthy relationships with youth in care

## Agenda

<b>Activity/Module:</b>	<b>Time:</b>
Welcome, Introduction & Overview	15 mins
Terms Clarification	25 mins
<b>Module 1: Sex Education in the United States</b>	-
Activity: Values Clarification Exercise	30 mins
Content Exploration: Sex Education in the United States	20 mins
Break	5 mins
<b>Module 2: Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible?</b>	-
Content Exploration: What does Trauma-Informed Mean? How does it relate to my role?	30 mins
Activity: Disclosure Role Play	30 mins
BREAK	15 mins
<b>Module 3: Sexual and Reproductive Health Resource Overview</b>	30 mins
Activity: Sex 101 Trivia	30 mins
BREAK	5 mins
Wrap Up: Trauma-Informed Sex Education for Youth in Child Welfare: What is It, Why It Matters & Who is Responsible?	30 mins
<b>Total Time:</b>	<b>4.25 hours</b>

## Curriculum Format

This curriculum is stratified by various modules, within each module there will be an activity and/or opportunity for content exploration. Activities are designed to engage learners in a dynamic way, in which they will be encouraged to utilize their personal and professional expertise to inform the instruction of the curriculum. Content exploration is designed for the facilitator to engage the audience in content specific knowledge utilizing a conversational format.

Each module is presented in this curriculum in a table modeled in the form the example, below. Cells are dedicated to the following sections: summary, objectives, materials and facilitator notes. Some modules will include a suggested facilitator script. This is meant to be adapted for individual audiences and localities to the discretion of the facilitator.

Section Title	
<u>Summary:</u>	<u>Objective(s):</u>
<u>Materials:</u>	<u>Time Elapsed:</u>
<u>Facilitator Notes:</u>	

## Terms & Abbreviations

<b>Terms &amp; Abbreviations</b>	<b>Definitions</b>
Askable adult	An askable adult is a trusted figure in the lives of youth to whom they feel comfortable confiding relationship information regarding partners and SRH-related topics.
Dependency Courts, Child Welfare, Foster Care	These terms are used interchangeably, referring to institutions and systems involving child protective services to the degree that children are removed from the care of their biological parent(s,) involving the potential for the termination of parental rights, and placement of the youth in state care.
LGBTQ+	Lesbian, Gay, Bisexual, Transsexual, Questioning (including Intersex, and Asexual) Identifying-Individuals
SRH	Sexual and Reproductive Health
SRHHRE	Sexual and Reproductive Health and Healthy Relationships Education
STI	Sexually Transmitted Infection
Youth in Care	This term refers to youth who are in the guardianship of the state, whose biological parent(s') rights may or may not have been terminated or suspended.

# Welcome, Introduction & Overview

Summary: During this session facilitators and participants will establish ground rules to be used for the duration of the training. The facilitator will introduce topics to be covered in the training and accept any preliminary questions.

Objective(s):

- Introduce the training agenda and establish ground rules for the duration of the training

Materials:

- Whiteboard/chart paper & easel
- Markers

Time Elapsed: 15 mins

Facilitator Notes:

1. Use chart paper or whiteboard to write down group norms
  - It might be helpful to write a short list of group norms in advance, to use as a foundation, and add participant suggestions to the list
2. Accept and discuss suggestions from participants
  - Possible Guidelines to include:
    - Confidentiality: What's said in the group, stays in the group
    - Be respectful of others' opinions - even if you disagree
    - Use "I" statements--only speak for yourself
    - Respect everyone's space
    - Silence cell phones

Suggested Script:

*Welcome! Today we will discuss opportunities to support trauma-informed sexual health and healthy relationships education with youth in foster care. Throughout this training, participants will be given the opportunity to share personal beliefs and experiences on a number of sensitive topics. To ensure this is a safe space for people to share their thoughts, feelings, and experiences, we are going to establish group guidelines. What are some rules and/or expectations that would be beneficial to making sure that this is a respectful and safe environment for everyone?*

## Terms Clarification

Summary: During this session, facilitators and participants will review the terminology to be used in throughout the training.

Objective(s):

- Introduce common terminology that will be used throughout the training
- Agree on definitions that resonate with training participants

Materials: None

Time Elapsed: 25 mins

Facilitator Notes:

1. Introduce the following terms and definitions
2. Ask learners if each definition resonates with their knowledge/experience and, if not, ask how they would alter it (while remaining true to the definition)

Terms & Definitions:

Sex:

- “Biological traits that are socially associated with being male or female” (Zevallos, 2017)
- Can include, but is not limited to: oral, anal, and vaginal sex

*Sexuality:* “Sexual attraction, practices, and identity which may or may not align with sex or gender.” (Zevallos, 2017)

*Gender:* “The cultural and or social meanings attached to being feminine or masculine, which influence personal identities.” (Zevallos, 2017)

*Relationships:* Any mutually agreed upon level of commitment that occurs on a physical and/or emotional level

*Birth Control/Contraceptives:* any form of contraceptive that allows individuals to control their reproductive capacities that may or may not be used primarily for pregnancy prevention

*Trauma-Informed Care:* “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.” (Substance Abuse and Mental Health Services Administration, 2014)

Suggested Script:

*Before we dive into the training, let’s all get on the same page. Here [on slide] are some terms that we will be using throughout the training. I will present you with the definition, I encourage you to speak up and let us know – does that definition resonate with your experience/experience with youth? Would you keep the definition as is, or*



*would you change it? If so, how?*

# Module 1: Sex Education in the United States

Summary: This module will provide an overview of historical and current sex education policies and how localities implement sexual health curricula in public school settings. This will include information on abstinence-only and comprehensive sexual health education models, along with their associated outcomes.

## Objective(s):

- Educate stakeholders on the present state of sex education in the United States, including [A] its relevance to the youth in their care, and [B] the effectiveness and associated outcomes of abstinence-only and comprehensive sex education models; and [C] an overview of what the youth in their care/clients might be exposed to in typical American middle and/or high school educational settings

## Activity: Values Clarification Exercise

Summary: This activity allows participants to reflect on their own personal values and potential biases towards the diversity of sex, sexuality, and sex education practices among youth.

Objective(s):

- Learners will recognize that:
- Sexuality and gender are fluid and should not impact levels of respect, consent, and stigma within social groups and relationships
- Individuals enter sexual and emotional relationships/engagements with varying degrees of knowledge and experience
- Individuals enter sexual and emotional relationships/engagements with diverse personal histories

Materials:

- Online polling software
  - If software is not available: three signs labeled "No," "Sometimes/Maybe," and "Yes"
- Tape

Time Elapsed: 30 mins

Facilitator Notes:

1. Read each statement out loud and instruct participants to:
  - a. Select a response ("No," "Sometimes/Maybe," and "Yes") that best represents their comfort level/agreement with the statement that is read
  - b. If polling software is being used participants may respond anonymously
  - c. If software is unavailable, instruct participants to stand and move to the sign that reflects their response to each prompt
2. After each statement ask participants to reflect on what experiences have lead them to feel this way
  - a. Note: Not all statements are necessarily true, utilize these points of discussion to guide the conversation and raise participants' critical awareness of sex, sexuality, and sex education
  - b. Encourage resource sharing if there are community or web-based resources that enable stakeholders to be more comfortable with any given topic relevant to the discussion
3. Remind learners that regardless of their comfort levels and personal values that it is critical to address these topics with the youth

Comfort Continuum Statements:

1. I believe abstinence-only until marriage is a positive approach to sex education

2. Abstinence-only education models are empirically proven to reduce teen pregnancy and STI transmission
3. Abstinence-only educational models are generally inclusive of all gender and sexual identities
4. Abstinence-only educational models can be harmful to youth that have been exposed to sexual trauma
5. Schools are mandated to teach medically accurate information
6. Generally, teachers who teach health and sexuality courses have are trained in the subject
7. Sex education should include information on pregnancy prevention
8. Most sex education courses focus on penetrative sex
9. I am comfortable talking to my peers about healthy relationships
10. My peers and I often discuss STI prevention
11. STI prevention can occur within the context of casual sexual encounters/relationships
12. I believe that it is possible to prevent STI transmission
13. I know ways to effectively communicate condom negotiation
14. A relationship can be considered "healthy" if physical violence is not present
15. I believe generally everyone my age has the same amount of knowledge about sex and sexual health
16. Abstinence-only sex education is an acceptable form of sex education
17. Abstinence-only sex education reinforces gender stereotypes
18. Abstinence is an acceptable form of birth control
19. Abstinence is the most effective form of STI and pregnancy prevention
20. Sex education is important for middle and high school aged youth
21. The choice to use condoms should be made by both consenting parties
22. Condoms should always be used during sex
23. Are condoms good for protecting against STIs and pregnancy?
24. It is okay to be with someone even if you don't consider them 100% trustworthy
25. A partner should be enthusiastic when something goes well for you
26. People often use the word "crazy" to describe their partner(s)
27. It is okay if partners refuse to discuss topics that make them uncomfortable
28. Partners should be able to discuss past trauma at some point during their relationship
29. It is okay if partners lash out in order to express anger, frustration, and sadness
30. Dating apps are only for people who just want to have sex
31. Emotional and physical security are important in relationships
32. If a partner is not "turned on" it is okay to make moves to change their mind

# Content Exploration: Sex Education in the United States

Summary: This module provides a brief overview of national trends in sex education policies, curricula, and funding in public settings.

Objective(s):

- Provide stakeholders with a review of sex education policies and implementation strategies, including a diversity of sex education models such as abstinence-only and comprehensive sex education

Materials: None

Time Elapsed: 20 minutes

Facilitator Notes:

1. Sex Education Policies:

a. Vary by state

i. You can find policies on your state online at:

1. [SexEtc.org](http://SexEtc.org)
2. [Guttmacher.org](http://Guttmacher.org)
3. [PowertoDecide.org](http://PowertoDecide.org)

ii. This is supplemented by state by state information on [pregnancy](#) and [birth control availability](#) found at [PowertoDecide.org](http://PowertoDecide.org)

1. Note: Trainers are encouraged to interact with the aforementioned resources to engage learners in dynamic discussions about funding and policy action in their state

b. Federal funding does support abstinence-only models, often termed “sexual risk avoidance” curricula

2. Implementation Trends:

a. When investigating policies in your jurisdiction it is important to be critical of curriculum choice and implantation strategies, including:

- i. Facilitator training
- ii. Promotion of heteronormativity
  1. Curricula should be inclusive of LGBTQ+ youth

iii. Trauma-informed approaches

iv. Shameful messaging

v. Ask the audience!

1. This is a good point to check-in with participants about common practices that occur locally, and gauge their knowledge on policies and youth engagement

3. Where to look for resources

a. [Evidence-based teen pregnancy prevention \(TPP\) interventions](#): This webpage allows browsers to review selected evidence-based interventions and provides guidance on program selection based on individual program characteristics such as length, target population, and outcomes.

b. [Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol](#): This resource is authored by trauma-informed care experts, Dr. Roger D. Fallot and Dr. Maxine Harris. This tool provides an

overview of trauma in the context of service systems with evaluation and implementation guidelines.

[BREAK]

## Module 2: Trauma-Informed Sexual and Reproductive Health Services and Education: Who is Responsible?

Summary: This module will introduce stakeholders to their role as a potential trusted adult, caregiver, and/or extension of state care in the provision of developmentally appropriate, and comprehensive sex education. Additionally, this module will review tools and techniques that stakeholders can utilize in their practice directly with youth or indirectly with the other systems that youth interact with, i.e. educational and medical institutions to ensure that SRHHRE is provided in a trauma-informed manner that best suits the needs of youth in care.

Objective(s):

- Promote accountability among stakeholders for the provision of medically accurate, comprehensive, developmentally appropriate sex education and to illustrate the unique vantage point of child welfare stakeholders to intervene in this area
- Introduce stakeholders to trauma-informed approaches to the discussion of sexual health and healthy relationships education and related topic and increase stakeholder comfort levels regarding to their ability to practice such approaches

# Content Exploration: What does “trauma-informed” mean? How does it relate to my role?

Summary: This module will provide a brief introduction to the principles of a trauma-informed approach to interactions with youth in care, with attention to sexual and reproductive health practices and education, including an overview of how stakeholders can utilize these approaches within their unique role (social worker, lawyer, guardian ad litem, judge, etc.)

Objective(s):

- Provide stakeholders with an introduction to trauma-informed tools that can be utilized with youth focusing on SRH practices and education that can be triggering

Materials: None

Time Elapsed: 30 mins

Facilitator Notes:

1. Prompt the audience regarding their existing knowledge of trauma-informed care and how they utilize trauma-informed practices with youth in their care
  - a. Trauma-informed care is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as:
 

“A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.”

(Substance Abuse and Mental Health Services Administration, 2014)
  - b. Trauma-informed care and trauma-informed approaches are critical to programs that unite behind the common purpose of avoiding retraumatization, building resilience, and giving youth the tools to regulate emotions to become a functioning adult. In the context of professional relationships, trauma-informed services should be implemented in mental health, juvenile justice, child protective, and educational settings. (Hodas, 2006)
  - c. Encourage the audience to consider how these principles relate to their role
    - i. The Chadwick Center for Children and Families, along with other researchers, note that even though child welfare stakeholders and social service staff may be well trained in evidence-based programs to treat youth, many are unaware of trauma-informed methodologies. (Chadwick Center for Children and Families, 2009; Chaffin & Friedrich, 2004) The National Child Traumatic Stress Network designed the *Child Welfare Trauma Training Toolkit* in collaboration with several organizations focusing on mental and physical health in the context of seeking permanency and well-being for children. This toolkit offers stakeholders tools and strategies for



interacting with youth with a history of complex trauma that they may or may not be aware of as stakeholders (below.) (Child Welfare Committee & National Child Traumatic Stress Network, 2008)

1. Maximize the child's perception of safety
  2. Assist children in reducing overwhelming emotion
  3. Help children make new meaning of their trauma history and subsequent experiences
  4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships
  5. Coordinate services with other agencies
  6. Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services
  7. Support and promote positive and stable relationships in the life of the child
  8. Provide and support guidance to the child's family and caregivers
  9. Manage professional and personal stress
- d. It is important that stakeholders are able to recognize symptoms of trauma/triggers in youth
- i. Reference Figure 1: Symptoms of Trauma in Children/Adolescents Summary
  - e. Be aware that the audience might have received previous training regarding trauma-informed practices
2. For youth who may have experienced or witnessed sexual trauma events such as physician visits, conversations with peers/adults, health education etc. can be triggering
- a. Some solutions to this might be:
    - i. Confirm school's policies regarding sex education and which curriculum(s) are being implemented - if any at all
      1. Some sex education curricula, especially those focused on abstinence-only messaging can include triggering and/or shameful messages
    - ii. Research which evidence-based curricula are being implemented in your community that the youth could access
    - iii. Some physician visits can be triggering, especially for the purpose of STI testing, women's health visits, etc.
      1. For these purposes it can be helpful to:
        - a. Request a more experienced physician
        - b. Discuss the visit with the youth before the encounter informing them of their rights as a patient, discussing the sequence of the visit and testing/counseling practices, etc.
      2. Normalize and destigmatize pregnancy, parenting, premarital sex, and STI transmission
        - a. While some (with every good intention) may want to encourage youth to avoid these practices due their negative outcomes – using shameful messages

surrounding these topics can be extremely harmful for youth

b. Reference Figure 2: Reframing Shaming Messages in Sex Education

MODULE SUPPLEMENTS:

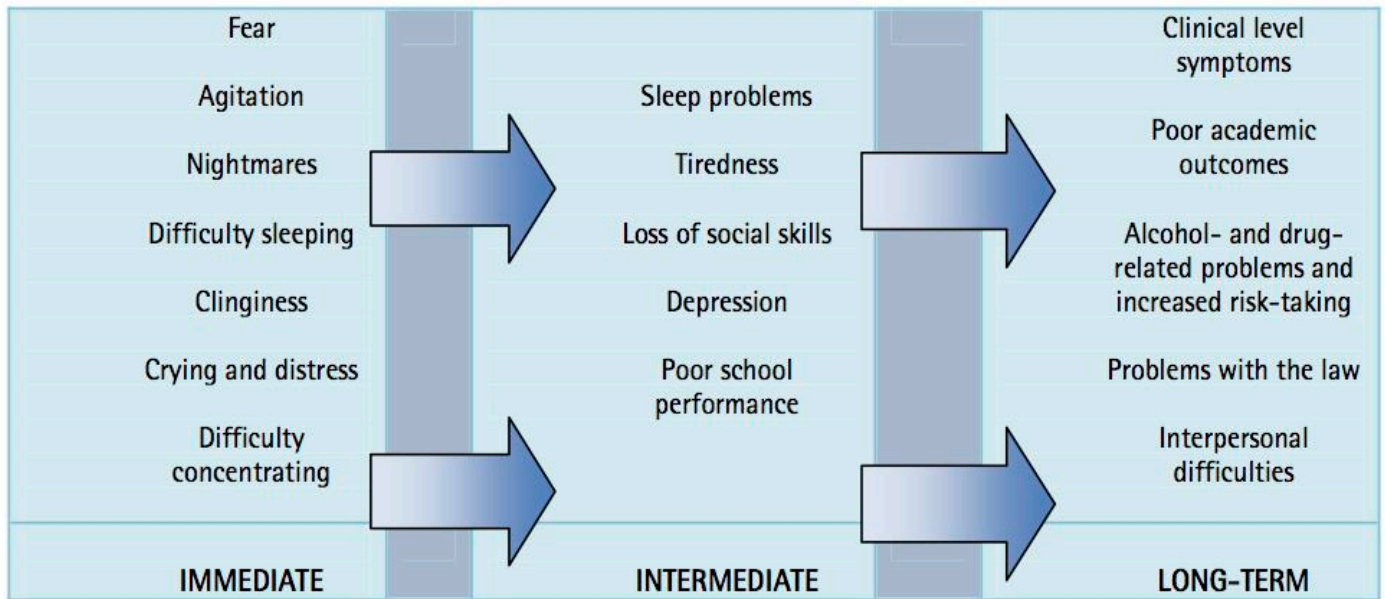


Figure 2: Symptoms of Trauma in Children/Adolescents Summary - (Kenardy, Le Brocque, March, & De Young, 2010)

<b>Common Shaming Messages</b>	<b>Possible Re-Frame</b>	<b>Rationale</b>
Most teen moms end up living in poverty	Raising a child is hard work and costs money; many parents find they need to sacrifice a lot in order to provide for their family. Think about your goals and dreams and about how having a child would fit into your plans. What are you willing or unwilling to sacrifice?	Removes stigma from pregnant or parenting teens
Don't be embarrassed to buy condoms; pregnancy or an STI are even more embarrassing!	It is important to work through feeling embarrassed about buying condoms; it is the responsible thing to do to protect yourself and your partner.	Removes element of shame from unintended pregnancy and STIs
Experimenting with sex to satisfy curiosity is unhealthy	Feeling curious about sex is something many young people go through as they become adults. If you are going to have sex, protect yourself! Use condoms and other barriers, and make sure you can communicate effectively with your partner(s).	Removes judgement/shame
You shouldn't have sex with someone you don't know very well	It's important to talk honestly and openly about safer sex with all of your partner(s).	Removes judgment/shame

*Figure 3: Reframing Shaming Messages in Sex Education (Schergen & Hebert, 2016)*

## Activity: Disclosure Role Play

Summary: This activity allows participants to utilize conversational techniques and tools in disclosure scenarios and visualize team-oriented communication strategies to support youth.

Objective(s):

- Provide stakeholders with strategies to utilize during conversations on disclosure with youth and how to use a team-based trauma-informed approach to facilitate care for youth

Materials:

- Caution tape/string/ribbon
- Sharpie
- Name tags for each role

Time Elapsed: 30 mins

Facilitator Notes:

1. Scenario: A stakeholder (facilitator's choice) receives a disclosure from a youth regarding a sexual trauma
2. The following roles will be utilized during this activity:(Participants may volunteer to personify each role - each volunteer should have a name tag with their title)
  - a. Judge
  - b. Lawyer
  - c. Guardian ad litem
  - d. Social worker
  - e. Nurse
  - f. Teacher
  - g. Foster parent
  - h. Therapist
  - i. Biological parent
3. Pass out the tape while participants are standing in a straight line
  - a. Each participant should hold on to the tape as it passes them, the last participant should hold the remainder of the roll (this end of the tape should still have a lot of slack)
  - b. Ask the participants to arrange themselves in a way that encourages communication (as opposed to a straight line where stakeholders can only communicate with those directly next to them)
    - i. Typically, participants will arrange themselves in a circle
4. Participants will pass the tape (beginning with the stakeholder that has the end of the roll,) representing their line of communication, to each other as they discuss what actions they would take and who they would communicate with in the given scenario
  - a. This should create a web-like structure, illustrating how various stakeholders can communicate with each other creating a supportive network for the youth
  - b. If there are two trainers, one should stand in the middle of the circle representing the youth in the scenario
    - i. This is beneficial in the sense that stakeholders can communicate directly with the youth and the other trainer can guide the scenario

as necessary

5. While encouraging participants to work through the scenario, engage audience members who are not playing an active role in the exercise to give suggestions/input on how the stakeholders could have approached the situation differently, etc.

[BREAK]

## Module 3: Sexual and Reproductive Health Resource Overview

Summary: This module will provide an overview of online and print resources that stakeholders can utilize to create trauma-informed relationships and provide appropriate SRHRE resources to youth.

Objective(s):

- Increase stakeholders' self-efficacy relating to the discussion of topics related to sexual health and health relationships
- Provide stakeholders with free, accessible, and understandable resources that can be utilized to support and sustain the discussion on sexual health and healthy relationships with youth in care

Materials: None

Time Elapsed: 30 minutes

Facilitator Notes:

1. Present audiences with the definitions of "Comprehensive Sex Education" and "Exemplary Sexual Health Education," give learners an opportunity to process each definition, ask if there is anything they would take away, add, take question with, or that requires clarification:
  - a. Comprehensive Sex Education: "A planned, sequential K-12 curriculum that is part of a comprehensive school health education approach which addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality. The curriculum should be designed to motivate and assist students to maintain and improve their sexual health, prevent disease and reduce sexual health-related risk behaviors. It should allow students to develop and demonstrate developmentally appropriate sexual health-related knowledge, attitudes, skills, and practices. The comprehensive sexuality education curriculum should include a variety of topics including anatomy, physiology, families, personal safety, healthy relationships, pregnancy and birth, sexually transmitted diseases including HIV, contraceptives, sexual orientation, pregnancy options, media literacy and more. It should be medically accurate. Qualified, trained teachers should provide sexuality education." (Future of Sex Education, n.d. )
  - b. Exemplary Sexual Health Education: "The Centers for Disease Control and Prevention/ Division of Adolescent School Health defines Exemplary Sexual Health Education as follows: 'A systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions, but also emphasizes sequential learning across elementary, middle, and high school grade levels. ESHE provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STD, and unintended pregnancy. ESHE is delivered by well-qualified and trained teachers, uses strategies that are relevant and engaging, and consists of elements that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on

effective sexual health education.” (Future of Sex Education, n.d. )

2. Present the following online resources to the audience and ask if they know of any community or other resources that can be utilized for sexual health knowledge and services. Allow time for discussion & note participant responses.
  - a. [Bedsider.org](http://Bedsider.org): Provides sexual health and relationship resources to a young adult audience (male & female) with a focus on birth control methods. Includes clinic finder features, videos, activities, and individualized programmable birth control reminders.
  - b. [StayTeen.org](http://StayTeen.org): Targets pre-teen and teen audiences with games, videos, a Q&A forum, with information on birth control, sex, relationships, and abstinence.
  - c. [SexEtc.org](http://SexEtc.org): This resource is appropriate for youth of all ages, including information on sexual health, featuring videos, games, conversation tools, and state by state fact sheets
  - d. [Amaze.org](http://Amaze.org): This resource targets youth aged 10-14 years, but can be utilized for older audiences, including engaging and informative video content on puberty, sexual orientation, gender identity, healthy relationships, personal safety, sex, and reproduction.
  - e. [National Sexuality Education Standards: Core Content and Skills, K-12](#): This resource can be utilized to critique and supplement the sex education standards and strategies to engage youth. This includes indicators and outcomes of comprehensive sex education programming. This should be utilized by educators and stakeholders.

## Activity: Sex Ed 101 Trivia

Summary: Learners will increase their knowledge base and identify gaps in knowledge in order to inform their clients about safe sex practices

Objective:

- Introduce and demystify sexual health topics

Materials:

- Online polling software

Time Elapsed: 30 minutes

Facilitator Notes:

1. Instruct the audience to utilize Poll Everywhere software in order to respond to the prompts
2. The audience is encouraged to ask questions and discuss the trends that are revealed through the polling software

Trivia Prompts:

1. Douching is good for my vagina and it prevents pregnancy after sex [FALSE]
2. A pregnancy can result from pre-ejaculate [TRUE]
3. It is necessary for all sexual activity to lead to orgasm [FALSE]
4. Vaseline or lotions can be used for lubrication [FALSE]
5. Condoms are not reusable [TRUE]
  - a. You can turn a condom inside out and reuse it [FALSE]
6. You can not use plastic substitutes for condoms [TRUE]
7. One can be "too big" for a condom [FALSE]
8. It is possible to use two condoms instead of one to make sure they don't break/double bagging [FALSE]
9. You can't get pregnant while you're on your period [FALSE]
10. Premature ejaculation is abnormal [FALSE]
11. You can "catch" an STI from a toilet seat [FALSE]
12. The morning after pill causes an abortion [FALSE]
13. Yeast infections can be spread by oral sex [TRUE]
14. I can use a condom when it is outdated [FALSE]
15. It's summer, I can use a condom that has been in my car for a few days [FALSE - do not use condoms that have]

Suggested Facilitator Script:

*Sex is all around us, it appears in music, tv, books, and many other forms of popular culture. However, much of what is known about sex from these outlets are myths not facts. It is important to be able to separate myth from fact so that youth can be informed and fight misconceptions perpetuated by media and peer groups. For this activity, I am going to say several statements that, if you feel called to do so, you can identify as true or false.*

[BREAK]



# Wrap Up: Trauma-informed Services & Sex Education for Youth in Child Welfare: What is it, Why it Matters & Who is Responsible?

Summary: This will allow stakeholders that opportunity to review and synthesize training content in a meaningful way that directly correlates to their role in the child welfare system

Objective:

- Review the significance of trauma-informed services with attention to sexual health topics for youth in care, and their responsibility in advocating for and communicating appropriate information to youth about their sexual health

Materials: None

Time Elapsed: 30 mins

Facilitator Notes:

1. This time is dedicated to the synthesis and review of training materials, encourage learners to ask questions and share resources
2. Reinforce to audiences that child welfare stakeholders are responsible for discontinuing the perpetuation of triggering practices not only to avoid re-traumatization of youth, but also to avoid secondary-trauma and compassion fatigue
3. Frame this statement as an opportunity to build rapport and trust with youth while enhancing their ability to seek services and encourage healthy behaviors leading to independent living

## References

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END THE STIGMA:  
A PEER-EDUCATION MODEL

**INCREASING  
KNOWLEDGE,  
SELF-EFFICACY &  
STARTING  
CONVERSATIONS**

Relationships, Consent, STIs &  
Pregnancy Prevention

BY: SARAH ASHLEY JOLLY

**End the STIigma: A Peer-Education Model**  
***Increasing Knowledge, Self-Efficacy & Starting Conversations: Relationships, Consent, STIs, and Pregnancy Prevention***

Overview & Objectives:

By the conclusion of this training, learners will gain the operative skills to become a certified peer mentor and Bedsider U campus representative for youth in extended foster care who are currently attending community colleges. Learners will practice initiating and maintaining sex-positive, inclusive conversations centering on healthy relationships in the context of consensual interactions, STI knowledge, and pregnancy prevention.

## Agenda:

<b>Activity/Module:</b>	<b>Time:</b>
Welcome, Introduction & Overview	20 minutes
Terminology Overview	25 mins
Values Clarification Exercise: Comfot Continuum	45 minutes
BREAK	5 mins
Birth Control Bingo	45 mins
Healthy Relationships Exercise	45 mins
BREAK	10 mins
Drawing the Line: How to Have Trauma-Informed Conversations on Consent	1 hour
LUNCH	1 hour
Fact & Fiction: Creating Informed Conversations Among Peers	1 hour
Role Play: Consent, Condom Negotiation, Friend-terventions & Discussion	1 hour
BREAK	15 mins
Wrap up: How to utilize conversational tools to be a peer mentor	20 mins
<b>Total:</b>	<b>~ 8 hours</b>

## Curriculum Format

This curriculum is stratified by various modules, within each module there will be an activity and/or opportunity for content exploration. Activities are designed to engage learners in a dynamic way, in which they will be encouraged to utilize their personal and professional expertise to inform the instruction of the curriculum. Content exploration is designed for the facilitator to engage the audience in content specific knowledge utilizing a conversational format.

Each module is presented in this curriculum in a table modeled in the form the example, below. Cells are dedicated to the following sections: summary, objectives, materials and facilitator notes. Some modules will include a suggested facilitator script. This is meant to be adapted for individual audiences and localities to the discretion of the facilitator.

Section Title	
<u>Summary:</u>	<u>Objective(s):</u>
<u>Materials:</u>	<u>Time Elapsed:</u>
<u>Facilitator Notes:</u>	

## Terms & Abbreviations

<b>Terms &amp; Abbreviations</b>	<b>Definitions</b>
Dependency Courts, Child Welfare, Foster Care	These terms are used interchangeably, referring to institutions and systems involving child protective services to the degree that children are removed from the care of their biological parent(s,) involving the potential for the termination of parental rights, and placement of the youth in state care.
LGBTQ+	Lesbian, Gay, Bisexual, Transsexual, Questioning (including Intersex, and Asexual) Identifying-Individuals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
Youth in Care	This term refers to youth who are in the guardianship of the state, whose biological parent(s') rights may or may not have been terminated or suspended.

# Welcome, Introduction & Overview

Summary: This module introduces participants to the training by providing an overview and establishing ground rules.

Objective(s):

- Introduce the training agenda and establish ground rules for the duration of the training

Materials:

- Whiteboard/chart paper & easel
- Markers

Time Elapsed: 20 mins

Facilitator Notes:

- Use chart paper or whiteboard to write down group norms
  - It might be helpful to write a short list of group norms in advance, to use as a foundation, and add participant suggestions to the list
- Accept and discuss suggestions from participants
  - Possible Guidelines to include:
    - Confidentiality: What's said in the group, stays in the group
    - Be respectful of others' opinions - even if you disagree
    - Use "I" statements--only speak for yourself
    - Respect everyone's space
    - Silence cell phones

Suggested Script:

*Welcome! Throughout this curriculum participants will be given the opportunity to share personal beliefs and experiences on a number of different sensitive topics. To ensure this is a safe space for people to share their thoughts, feelings, and needs, we are going to establish group guidelines. What are some rules and/or expectations that would be beneficial to making sure that this is a respectful and safe environment for everyone?*



# Terminology Overview

Summary: This activity will clarify SRH terminology and participants agree on terminology that will be utilized throughout the training.

Objective(s):

- Establish clear and practical definitions for SRH terminology that will be utilized throughout the training

Materials: None

Time Elapsed: 25 mins

Facilitator Notes:

- Introduce the following terms and definitions
- Ask learners if each definition resonates with their knowledge/experience and, if not, ask how they would alter it (while remaining true to the definition)

Terms & Definitions:

Sex:

- “Biological traits that are socially associated with being male or female” (Zevallos, 2017)
- Can include but is not limited to oral, anal, and vaginal sex

Sexuality: “Sexual attraction, practices, and identity which may or may not align with sex or gender” (Zevallos, 2017)

Gender: The cultural and or social meanings attached to being feminine or masculine, which influence personal identities (Zevallos, 2017)

Relationships: Any mutually agreed upon level of commitment that occurs on a physical and/or emotional level

Birth Control/Contraceptives: Any form of contraceptive that allows individuals to control their reproductive capacities, may or may not be used primarily for pregnancy prevention by heterosexual or LGBTQ+ identifying individuals

Suggested Script:

*Before we dive into the training, let’s all get on the same page. Here [on slide] are some terms that we will be using throughout the training. I will present you with the definition, I encourage you to speak up and let us know – does that definition resonate with your personal experience or educational experiences? Would you keep the definition as is, or would you change it? If so, how?*

# Values Clarification Exercise: Comfort Continuum

Summary: This activity allows participants to reflect on their own personal values and potential biases towards the diversity of sex, sexuality, and sex education practices among youth.

Objective(s):

Learners understanding of the following concepts will be increased after completion of this activity:

- Sexuality and gender are fluid and should not impact levels of respect, consent, and stigma within social groups and relationships
- Individuals enter sexual and emotional relationships/engagements with varying degrees of knowledge and experience
- STI prevention can be achieved through conversation and dynamic steps to reduce risk through condom negotiation and effective usage

Materials:

- Polling software
- [If software is unavailable:] 3 signs labeled "No," "Sometimes/Maybe," and "Yes"
- Tape

Time Elapsed: 45 mins

Facilitator Notes:

- Read each statement out loud and instruct participants to:
  - If software is available, use to illustrate participant responses
  - If software is unavailable, instruct participants to go to the sign that best represents their comfort level with the statement that is read
- After each statement ask participants to reflect on what experiences have lead them to feel this way
- Throughout the exercise ask participants what experience have increased their comfort level that they can share with others
- Remind learners that regardless of their comfort levels and personal values that it is critical to address these topics with the youth

Comfort Continuum Statements:

1. I am comfortable talking to my peers about healthy relationships.
2. My peers and I often discuss STI prevention
3. STI prevention can occur within the context of casual sexual encounters/relationships.
4. I believe that it is possible to prevent STI transmission
5. I know ways to effectively communicate condom negotiation
6. A relationship can be considered. "healthy" if physical violence is not present.
7. I believe generally everyone my age has the same amount of knowledge about sex and sexual health

8. Abstinence only sex education is an acceptable form of sex education
9. Abstinence only sex education reinforces gender stereotypes
10. Abstinence is an acceptable form of birth control
11. Abstinence is the most effective form of STI and pregnancy prevention
12. Sex education is important for middle and high school aged youth
13. The choice to use condoms should be made by both consenting parties.
14. Condoms should always be used during sex
15. Are condoms good for protecting against STIs and pregnancy?
16. It is okay to be with someone even if you don't consider them 100% trustworthy
17. A partner should be enthusiastic when something goes well for you.
18. People often use the word "crazy" to describe their partner(s)
19. It is okay if partners refuse to discuss topics that make them uncomfortable
20. Partners should be able to discuss past trauma at some point during their relationship.
21. It is okay if partners lash out in order to express anger, frustration, and sadness
22. Dating apps are only for people who just want to have sex
23. Emotional and physical security are important in relationships
24. If a partner is not "turned on" it is okay to make moves to change their mind
25. It is okay to give someone credit for being "kind/nice"

# Sexy Bingo

Summary: This module offers the opportunity to gain a greater understanding of the risks and benefits associated with specific types of birth control, sexual health and pleasure-related technologies that can be utilized by males or females.

Objective(s):

- Participants will be able to name different types of birth control and associated characteristics

Materials:

- Birth Control Bingo Cards (Laminated)
- Markers
- Wipes – to clear bingo cards

Time Elapsed: 45 mins

Facilitator Notes:

- Read the following statements in the order of your choice
  - Each statement describes a form of birth control, as illustrated on participants' bingo cards
  - Encourage participants to guess which method you are describing, before revealing the correct answer
    - Questions and discussion should be encouraged

Bingo Prompts:

- Implants
  - The MOST effective form of birth control currently on the market
  - Requires minor surgical insertion and removal and can last for multiple years
- Lube
  - Can heighten pleasure and assist in foreplay and sex
- Pap Smear
  - A routine clinical test that checks for abnormalities in cervical cells, used to prevent cancer
- Spermicide
  - The least effective birth control method, according to the CDC this method has a 28% failure rate - meaning that on average 28 out of 100 women using this method will experience an unintended pregnancy
- IUD
  - The second most effective form of birth control
  - Still more effective than female sterilization
  - Does not protect against STI transmission
  - Normal fertility returns immediately
- The Shot [Depo-Provera]
  - Requires multiple visits to a physician
  - 6% failure rate
- Vibrator

- Can be used by individuals or partners to increase sexual pleasure
- Can be used during foreplay and sex
- Can include multiple points of stimulation
- The Patch
  - May be visible while wearing it
  - Same failure rate as the pill, and the ring
- The Ring
  - Good, discrete birth control option
  - Worn on the cervix
  - Same failure rate as the pill, and the patch
- Dental Dam
  - Device that will protect from STI transmission during oral sex
- The Pill
  - 9% failure rate (typical use)
  - To be most effective should be taken daily around/at the same time
- Condom
  - One of two methods that protects users against STI transmission
- Withdrawal
  - One of the oldest methods of contraception
  - 22% failure rate
  - Requires a lot of practice and precision
- Internal or Female Condom
  - Comparable failure rate to the traditional condom
  - Can be inserted hours before sex
- Fleshlight
  - Can be used for pleasure alone or with a partner
  - Great for long distance relationships
- Emergency Contraception
  - Can be used after unprotected sex to reduce the risk of pregnancy – however, the sooner it is used the more likely it is to be effective
  - The most effective form of emergency contraception is the ParaGaurd IUD, which can be inserted up to five days after unprotected sex
  - Pill options are also effective
  - Try PlannedParenthood.org for more information about which method would be right for you – this can be dependent on when you had sex, your weight, and accessibility

Suggested Script:

*During this activity, each of you will receive a "bingo" card with various kinds of birth control, sexual health, and pleasure-related technologies. I am going to ask that you guess what I am referring to as we go along, the first participant with "bingo" will win a prize!*

# Healthy Relationships Exercise: Red, Yellow & Green Flag

Adapted from: (Break the Cycle, 2014)

Summary: This exercise will prepare learners to initiate conversations on healthy relationships with their peers and provide them with the tools to engage peers in critical analysis of common abusive and/or risky behaviors.

Objective(s):

- Learners will critically engage a/typical behaviors in the context of a romantic relationship and develop a greater awareness for unhealthy behaviors and appropriate responses

Materials: None

Time Elapsed: 30 mins

Facilitator Notes:

- Instruct learners to read each statement on the PowerPoint - it would be most effective to have one learner read each statement to engage the audience
- Explain that each statement contains an example of a behavior that might be present in a dating relationship
- Encourage learners to consider what they might do if that action were occurring in their relationship: "stay together" "let's talk about it" or "it's over" indicating whether the action is a red flag (it's over,) yellow flag (caution - let's talk about it,) or green flag (that's okay/acceptable -stay together)
- At each statement is read, facilitate a short conversation
  - Allow learners to make suggestions as to what they would or would not do and why

Statements:

1. Hey, you saw your friends yesterday, why do you have to see them tonight too?
2. Hey, that is kind of tight, I don't really want you going out like that
3. They admit to going through your phone while you were in the shower
4. Repeated abuse of drugs and alcohol (i.e. your partner comes home intoxicated more than 4 days in a week)
5. I decided to stop taking my birth control two weeks ago
6. Shows up unexpectedly to your place three times in a week
7. Insists on using read receipts/ upset when you don't answer the phone or can't talk
8. Punches a wall in anger
9. Always insists on sleeping over
10. I don't want to use condoms, why is it important if we are only seeing each other?
11. If you don't, I am going to out you to your friends/family
12. Since you just got paid, would you mind if I had some money to go out with my friends?

Suggested Script:

*During this activity, we are going to discuss some behaviors that might occur within*

*the context of any romantic relationship. Statements will appear on the presentation, we will take turns reading and responding to each statement. After each statement is read, consider whether this behavior would be a "red flag" i.e something that would end the relationship, a "yellow flag" a sign of caution that partners could talk through to clarify and gain a respectful understanding of the other's point of view, or a "green flag" which would be a completely acceptable form of behavior that you have no issues with, etc.*

# Drawing the Line: How to Have Trauma-Informed Conversations About Consent

Summary: This activity acknowledges conversations on consent and explores how previous trauma can affect current relationships.

Objective(s):

- Generate a discussion to increase learners' comfort levels with discussed consent using a trauma informed approach while leveraging their own expertise

Materials: None

Time Elapsed: 30 mins

Facilitator Notes:

- Encourage participants if not already, to sit in a circle. Introduce the topic of trauma informed consent, reassure learners' that this is a safe space, and that the most valuable information on consent is what comes from them

Discussion Questions:

- What is trauma informed consent?
  - Definition: Trauma informed consent recognizes that trauma and other personal experiences influence one's present perceptions and attitudes of the world around them – including sex and relationships
- Do you talk to your friends about consent?
  - What is consent?
  - Ask participants why or why not?
  - Does this conversation only come up after an incident has occurred? (Either a violation of consent or a positive experience)
    - Which do you find more common among your peers?
- Why is it challenging to talk about consent?
  - Did you ever have any instruction/conversations including consent at school or at home?
- How can consent be given?
  - Verbal or nonverbal cues
- What are some ways someone could revoke consent?
  - Verbally or nonverbal cues
- What is coercion?
  - *"If someone makes you feel obligated or forced to do something you don't want to, you may be experiencing coercion. By definition, sexual coercion is 'the act of using pressure, alcohol or drugs, or force to have sexual contact with someone against his or her will' and includes 'persistent attempts to have sexual contact with someone who has already refused.' Think of sexual coercion as a spectrum or a range. It can vary from someone verbally egging you on to someone actually forcing you to have contact with them. It can be verbal and emotional, in the form of statements that make you feel pressure, guilt or shame. You can also be made to feel forced through more subtle actions. For example, your*



*partner might:*

- *Make you feel like you owe them — ex. Because you're in a relationship, because you've had sex before, because they spent money on you or bought you a gift, because you go home with them*
  - *Give you compliments that sound extreme or insincere as an attempt to get you to agree to something*
  - *Badger you, yell at you or hold you down*
  - *Give you drugs and alcohol to loosen up your inhibitions*
  - *Play on the fact that you're in a relationship, saying things such as: "Sex is the way to prove your love for me" or "If I don't get sex from you I'll get it somewhere else"*
  - *React negatively (with sadness, anger or resentment) if you say no or don't immediately agree to something*
  - *Continue to pressure you after you say no*
  - *Make you feel threatened or afraid of what might happen if you say no*
  - *Try to normalize their sexual expectations: ex. 'I need it, I'm a guy.'"*
- (LoveIsRespect, 2014)

- What are some reasons why someone wouldn't want to talk about consent?
  - How can you encourage positive proactive conversations among your peers?
- What are signs someone is uncomfortable?
  - Verbal:
    - Asking to leave
    - Suggestion of an alternative activity (away from sexual engagement)
    - Attempts to engage in a public setting (vs. private)
  - Nonverbal:
    - Closed body language
      - I.e. crossed arms
    - Lack of eye contact
    - Lack of verbal engagement
    - Constantly checking their phone
    - Pulling away
    - Fidgeting
- What are some techniques you can use when a friend discloses trauma to you?
  - What to do: (*Ending Violence Association of British Columbia, n.d.*)
    - Use inclusive language
    - Employ non-blaming terminology
    - Offer immediate belief in their experience (validate their emotions either verbally or nonverbally by nodding while they are speaking)
    - Gauge/ask - if appropriate - what they would like to do and support their decision
    - Encourage them to seek medical/mental health support
    - Be aware that when retelling the trauma this may trigger flashbacks and other stressful reactions, utilize grounding techniques to support them at this time

- Counting or naming object in a room
- Keeping eyes open
- Taking deep breaths
- What NOT to do: (Ending Violence Association of British Columbia, n.d.)
  - Minimize facial expressions and reactivity
    - Focus on the survivor, do not recall a similar experience that you may have had
  - Do not question the “truth” of survivor’s version of events, especially if they reveal that they would like to report the incident
  - Do not ask for details of the event, especially extraneous factors such their appearance and/or the location of the event
    - Do not prompt the survivor about actions you might have taken in their situation (i.e. reporting, fighting back, discontinuing contact with the perpetrator)

# Fact & Fiction: Creating Informed Conversations Among Peers

Summary: This activity serves to demystify sexual health topics among youth in order to create a reliable knowledge base among peer groups.

Objective(s):

- Learners will increase their knowledge base in order to inform their peers about safe sex practices

Materials: None

Time Elapsed: 30 mins

Facilitator Notes:

- Instruct the audience to utilize polling software in order to respond to the prompts
- The audience is encouraged to ask questions and discuss the trends that are revealed through the polling software

Prompts:

1. Douching is good for my vagina and it prevents pregnancy after sex [FALSE]
2. A pregnancy can result from pre-ejaculate [TRUE]
3. It is necessary for all sexual activity to lead to orgasm [FALSE]
4. Vaseline or lotions can be used for lubrication [FALSE]
5. Condoms are not reusable [TRUE]
  - a. You can turn a condom inside out and reuse it [FALSE]
6. You cannot use plastic substitutes for condoms [TRUE]
7. One can be "too big" for a condom [FALSE]
8. It is possible to use two condoms instead of one to make sure they don't break/double bagging [FALSE]
9. You can't get pregnant while you're on your period [FALSE]
10. Premature ejaculation is abnormal [FALSE]
11. You can "catch" an STI from a toilet seat [FALSE]
12. The morning after pill causes an abortion [FALSE]
13. I can use a condom when it is outdated [FALSE]
14. It's summer, I can use a condom that has been in my car for a few days [FALSE - do not use condoms that have been exposed to heat, they are more likely to break.]
15. A good way to learn about sex without asking anyone is to watch porn. [FALSE - porn does not illustrate safe sex practices such as condom use and consent]
16. There is a vaccine that prevents the transmission of various strands of HPV - a virus that causes cervical cancer. [TRUE]

Suggested Script:

*Sex is all around us, it appears in music, tv, books, and many other forms of popular culture. However, much of what is known about sex from these outlets are myths not facts. It is important to be able to separate myth from fact so that ourselves and our*

*loved ones can stay healthy. For this activity, I am going to say several statements that, if you feel called to do so, you can identify as true or false.*

## Role Play: Consent, Condom Negotiation, Consent & Friend-terventions

Summary: This activity will aid learners in developing the communication tools necessary to initiate conversations on topics relating to sex and relationships.

Objective(s):

- Normalize conversations on condom negotiation, consent, and guided conversations on healthy relationships among peers

Materials:

- Male Condoms
- Female Condoms
- Script/Scenario Cards [see appendix]

Time Elapsed: 30 mins

Facilitator Notes:

- Pass out scenario prompts [see appendix]
  - Depending on the audience size, there is the option to split individuals into pairs or group the entire audience into a circle and go through each card together
- Discuss the “ideal” and “typical” conversations that partners might have re: consent, condom negotiation, intervening with a friend
  - Encourage students to think about what prevents the “ideal” conversations from happening and what enables “typical” scenarios
- Male and Female condoms can be used as props during role play, this also serves to familiarize the audience with handling and discussing common contraceptives

Suggested Script:

*Now, we are going to use some of the skills we have discussed throughout the training to do a role play exercise. I encourage you to draw on your own experience, if you are comfortable doing so, to discuss the “typical” and “ideal” responses to the scenario.*

## Wrap-Up: How to Utilize Conversational Tools to be a Peer Mentor

<p><u>Summary:</u> This module summarizes training content and provide learners with practical implementation guidelines.</p>	<p><u>Objective(s):</u>          → Review the significance of conversational tools and peer support re: sexual and reproductive health and pregnancy prevention</p>
<p><u>Materials:</u> None</p>	<p><u>Time Elapsed:</u> 30 mins</p>

Facilitator Notes:

- Ask participants if there is anything that was not covered in the training that they would like to know more about
- Accept questions about materials that were covered
- Reinforce the significance of peer support re: SRH and pregnancy prevention

Suggested Script:  
*You are now certified Bedsider U reps, this means that you can lean on Power to Decide, specifically Bedsider U, as a resource for among your peers and on campus. As we have said throughout this training – you all are the experts on what works with young adults, we are simply here to give you the tools to be successful. Young people have the right to medically accurate information on sexual health and the ability to control, when and under what circumstances to become pregnant.*

*We have covered a lot in this training. Are there any questions about what we have covered, or items that you would like more information on?*

## APPENDICIES

APPENDIX A: SCENARIO CARDS

<p>Scenario: Condom Negotiation</p> <p>Excuse: Let's not use condoms, just this one time</p>	<p>Describe the ideal conversation about consent with someone you recently started dating after meeting online</p>	<p>Describe what usually happens around consent with someone you recently started dating after meeting online</p>
<p>Scenario: Condom Negotiation</p> <p>Excuse: I don't want to use condoms, I don't like the way they feel</p>	<p>Scenario: Grey Area</p> <p>Two adults have attended a party and consumed a considerable amount of alcohol and they decide to taxi home together</p> <p>[RE: Consent - Describe the typical and ideal scenarios]</p>	<p>Scenario: Disclosure</p> <p>Your friend discloses a traumatic experience to you, what techniques would you use to handle this conversation?</p>
<p>Scenario: Condom Negotiation</p> <p>Excuse: Why would we use condoms, aren't you on birth control?</p>	<p>Scenario: Condom Negotiation</p> <p>Excuse: Why would we use condoms, are you cheating on me?</p>	<p>You meet your date at their place and they drive you to eat a lovely dinner, however, you aren't really feeling it. They drive you back to their place and insist you come in. How does this conversation play out?</p>



## APPENDIX B: BEDSIDER U REPRESENTATIVE INFORMATION & CERTIFICATE

This certifies that \_\_\_\_\_ is a certified Bedsider U representative. Bedsider U representatives have access to print and electronic resources distributed by Power to Decide. Bedsider U representatives are encouraged to engage with their peers and utilize technical support appropriate to peer informational sessions and campus activities.

## References

- Break the Cycle. (2014). Stay/Talk/Go. *Activity Guides*. Retrieved from <https://www.breakthecycle.org/sites/default/files/Break%20the%20Cycle%20Activity%20Guides.pdf>
- Ending Violence Association of British Columbia. (n.d.). *Responding to a Sexual Assault Disclosure: Practice Tips for Universities & Colleges* Retrieved from [http://www.okanagan.bc.ca/Assets/Departments+\(Administration\)/Student+Services/OC+Safety+and+Security/Response+Tips.pdf](http://www.okanagan.bc.ca/Assets/Departments+(Administration)/Student+Services/OC+Safety+and+Security/Response+Tips.pdf)
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