STARRSA

Cognitive Behavioral Treatment Program (CBT) Manual

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Cognitive Behavioral Treatment Program Manual

STARRSA:
Science-based Treatment, Accountability, and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice
Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

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INTRODUCTION

STARRSA:
Science-based Treatment, Accountability, and Risk Reduction for Sexual Assault

PROGRAM OVERVIEW

> This manual (STARRSA CBT) was created to be used by licensed clinicians administering this CBT program for students found responsible for sexual misconduct.

The STARRSA programs consist of two empirically based interventions; a Cognitive Behavioral Treatment (CBT) program and an Active Psychoeducation (AP) program designed to cover the range of sexual misconduct behaviors. Sexual misconduct includes a spectrum of behavior ranging from sexual harassment, sexually-inappropriate advances, stalking, and sexual pressure to battery that may itself range from groping and unwanted sexual touch to aggravated rape. The STARRSA CBT program is designed to treat a range of more serious sexual misconduct involving hands on physical contact, while the AP program is limited in scope, intended for less serious sexual misconduct behaviors such as stalking, harassment, sexual pressure, and instances where there appear to be a knowledge deficit or social skills deficits.

The STARRSA programs are intended to be part of a comprehensive campus-wide sexual violence prevention program that includes primary, secondary, and tertiary prevention programming, reducing known risk factors and promoting healthy sexual behavior and relationships. It is therefore part of a campus administrative process and not a criminal procedure. An important part of any university's sexual violence prevention plan,

however, is a strong working relationship with law enforcement community. Not only is this relationship important for the comprehensive criminal investigation and prosecution of reported incidents of sexual misconduct, it may be helpful for the law enforcement community to be a partner when developing and implementing campus-wide prevention programming. Importantly, however, the ultimate decision to report a complaint to law enforcement is entirely up to the Complainant.

The STARRSA programs are effectively secondary intervention, intended to provide clinical or educational interventions to those individuals who have been found responsible for sexual misconduct by Student Conduct Professionals, behavior that violates the university's code of conduct. A potential consequence, or sanction, for such behavior is referral to one of these programs. Student Conduct Processes use a lower burden of proof, typically a "preponderance of evidence" or in some cases a "clear and convincing" standard, compared to "beyond a reasonable doubt" in a criminal court proceeding. Thus, it is possible that a student might be found responsible for sexual misconduct in a campus Student Conduct hearing and acquitted of the same allegations / charges in a criminal trial. Neither STARRSA clinicians or facilitators should ever assume any investigative or prosecutorial role, but should work to help students successfully accomplish appropriate treatment or psychoeducational goals.

PROGRAM MISSION

The mission of this treatment program is to address and reduce sexual misconduct on campus. To this end, the goals of this program include assisting those who have engaged in sexual misconduct in developing beliefs, attitudes, and behaviors that promote healthy, consensual, and safe intimate relationships and being accountable for their sexual behavior. This treatment program utilizes a multi-modal, empirically-based approach to risk and needs assessment and treatment of students who have engaged in sexual misconduct. Its mission is to be consistent with and complement campus policies that are designed to address campus sexual misconduct, hold those responsible accountable, and assist those who have engaged in sexual misconduct in developing beliefs, attitudes, and behaviors that promote healthy, consensual, and safe intimate relationships and sexual behavior.

Although the CBT Program is intended to address the full spectrum of sexual misconduct, including more serious cases, it should be evident that in rare cases the sexual misconduct may be so severe or egregious that more thorough assessments and more intensive treatment of longer duration is required than is provided by this relatively short-term (typically 8-10 sessions) intervention and other more appropriate measures should be considered to ensure campus safety.

The two STARRSA programs are intended to be strictly voluntary for students. They are not intended to be used as a mandatory sanction or as punitive measure. They are intended to provide students with an opportunity to make positive changes in behaviors and attitudes, to increase understanding and sensitivity, to develop prosocial relationships, and to prevent reoccurrence of sexual misconduct. Although we clarify in greater detail subsequently how we use the term sanction, it refers herein to the outcome or the consequences of a hearing regarding a finding of sexual misconduct. By mandatory, we mean that which is compulsory and/or involuntary.

PROGRAM PHILOSOPHY

This program is rooted in the basic understanding that the vast majority of college students are emerging young adults still in the throes of psychosocial and psychosexual development, a stage well known to be characterized by social, emotional, and cognitive immaturity, risk taking, and poor decision-making. Many are highly impressionable, and readily influenced by their peers; most are drawn to partying and "hooking up."

Most of these characteristics are exaggerated by alcohol. Far from being immutable, however, their sexual misconduct may be highly responsive to effective interventions that reduce bad decisions leading to injurious behavior and promote safe, healthy, prosocial behavior in intimate relationships. Relative to adults, adolescents tend to be much more amenable to treatment intervention and have a good prognosis.

Primary Treatment Goal

The primary goal is to facilitate positive behavioral change by targeting and reducing risk relevant thoughts, feelings, and behaviors associated with sexual misconduct and promoting respectful, prosocial intimate relationships.

Treatment Objectives

- Individualize and maximize the effectiveness of therapeutic interventions through evidence-based assessment to identify risks and needs.
- Engage the client in the assessment and treatment process by identifying positive outcomes that can result from participating in the treatment program.
- Facilitate and enhance the client's motivation throughout the treatment program.
- Improve the client's self-awareness, self-monitoring, and decision-making.
- Target dynamic risk factors associated with sexual misconduct and related treatment needs while supporting and increasing the client's strengths and protective factors.

Treatment Approach

The treatment approach is cognitive-behavior therapy and follows a Risk-Needs-Responsivity Model (RNR, to be discussed). Treatment begins with a clinical risk and needs assessment that guides the cognitive-behavioral treatment intervention. Initial and periodic re-assessment help the clinician in determining the amount of time and focus needed for each domain (Module). The duration of treatment will depend on the assessed risks and needs. The number, frequency, and length of the sessions are based on treatment needs and the clinician's professional judgment. It has been reported during the pilot phase that the required number of sessions averaged from 8 to 10, with some lasting up to 15.

Empirically based treatment

To the best of our knowledge, STARRSA CBT (Cognitive Behavioral Treatment) is the first empirically-based program for the psychological treatment of college students found responsible for sexual misconduct. The section on STARRSA Program Components describes the development and piloting of this program.

This program is based on reviews of the research literature on risk factors associated with college student sexual misconduct, as well as adults and juveniles who have been adjudicated for sexual offenses. The target population is emerging adults in the age range of 18 to 25-30 who have violated student conduct policies regarding sexual misconduct and have not been adjudicated in a court of law.

STARRSA PROGRAMS IN CONTEXT

For over half a century, the high incidence of sexual misconduct on college campuses has been known to academic researchers, campus administrators, and college students alike. Thousands of programs, campaigns, hearings, laws, and initiatives have sought to end the violence in a measurable way, but none have proved comprehensively successful on a single campus or more broadly. Despite noteworthy progress in terms of general awareness, prevention education, bystander intervention, offender accountability, and victim support/ advocacy, the problem persists.

As a part of continuing, nationwide, efforts to reduce sexual misconduct from college campuses, the STARRSA Program has created an optional and voluntary treatment program that can help college students found responsible for sexual misconduct in a campus disciplinary process develop healthy interpersonal and intimate relationships and reduce the likelihood that they will engage in sexual misconduct again. To understand how STARRSA fits into the current efforts to combat sexual misconduct on campus, this section discusses: 1) the scope of the problem: 2) an overview of student conduct processes regulating sexual misconduct and their relationship to criminal legal processes: 3) STARRSA's contribution to current practice: 4) parameters and limitations of the STARRSA Project: and 5) the Project's foundational assumptions.

A. Scope and Legal Framework

The STARRSA Program relates specifically to college students who have been found responsible for sexual misconduct in a campus disciplinary process. At present, there are more than 4,000 postsecondary institutions in the United States with more than 19 million students enrolled. This includes both 2 and 4-year degree-granting institutions, public and private, and a broad diversity of students. RAINN (Rape, Abuse & Incest National Network) reports that approximately 11% of all students experience rape or sexual assault through physical force, violence, or incapacitation.[i] Among female undergraduate students, the rate approximates 1 out of 4 (23%) and among male undergraduates the rate is around 5.4%.[ii] Those rates grow even higher when broadened to include other forms of sexual misconduct, including dating violence, domestic violence, stalking, and sexual harassment. More than half of the sexual assaults on a college campus occur during the first few

months of Fall Term[iii] and only a fraction of students report their experience to proper authorities, including their postsecondary institution or local police.[iv]

To regulate this behavior, Congress has enacted a series of laws that simultaneously protect students from sexual violence, hold students who engage in sexual misconduct accountable for their behavior, and preserve the privacy of student records. They include:

- Title IX of the Education Amendments of 1972 (Title IX), which prohibits sex-based discrimination at institutions receiving federal funding;
- The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act), which, among other things, requires the compilation and annual public reporting of certain criminal offenses occurring on or around campus, including rape, incest, fondling, statutory rape, domestic violence, dating violence, and stalking; and
- The Family Educational Rights and Privacy Act (FERPA) of 1974, which requires institutions to protect as private any personally identifiable student records.

The U.S. Department of Education enforces each of the above and issues Title IX related guidance through the Office for Civil Rights.

State law can play an equally important role in regulating student sexual misconduct. California, for example, requires an affirmative consent standard in determining whether consent was given by both parties to sexual activity. It also requires a preponderance of the evidence standard in determining responsibility for sexual misconduct. Postsecondary institutions in the United States must comply with all applicable federal, state, and local law when coordinating processes designed to hold students accountable for behavior that violates institutional policy. This is most often done in the form of student conduct processes designed to address sexual misconduct.

B. Overview of Student Conduct Process and Relationship to Law Enforcement

Although known by different names across the country (including Title IX process, student behavior process, campus judicial process, etc.), the STARRSA Program is intended for any and all campus-based disciplinary processes designed to hold a student accountable for violating institutional policy as a student conduct process. Most often used to address non-academic behavioral issues, like underage alcohol or academic issues, like cheating and plagiarism, these processes have been called upon more frequently in recent years to address student sexual misconduct.

A typical student conduct process involving sexual misconduct begins when the institution is put on notice of the alleged behavior. This occurs when a "responsible employee" of the institution knows or, in some cases, reasonably should know about the alleged sexual misconduct. A responsible employee is "any employee who has the authority to take action to redress the harassment, who has the duty to report to appropriate school officials sexual harassment or any other misconduct by students or employees, or an individual who a

student could reasonably believe has this authority or responsibility."[v] The only institutional staff members who are not compelled to report the behavior are those authorized to maintain confidential communications with students (e.g. a therapist or clinician) and those whom students could not reasonably believe have the authority or responsibility to report sexual misconduct (e.g. a member of the grounds department who overhears one student telling another about a sexual assault, while the students walk by an area in which that staff member is working). Once on notice, responsible employees must report what they know to the appropriate school official. In most instances, this is the Title IX Coordinator or a Deputy Title IX Coordinator – either of whom may also have different or additional organizational titles.

For ease of reference, the STARRSA Program refers to any college or university staff member who administers a student conduct process as a student conduct professional. This may include individuals who identify as a Title IX Coordinator, Deputy Title IX Coordinator, Title IX Investigator, Director of Student Conduct/Judicial Affairs/Conflict Resolution/Community Standards, Dean of Students, Assistant/Associate Dean of Students, or similar organizational titles. These individuals are responsible, individually or in partnership with others, for administering processes that promptly, fairly, and effectively respond to reported sexual misconduct. They are also responsible for making sure the institution takes reasonable steps to end the misconduct, prevent its recurrence, and remedy its effects.

At present, there are various models for accomplishing this work. Some institutions utilize a single investigator model that charges a trained staff member with comprehensively investigating the reported misconduct and determining whether the accused student violated any institutional policy. In increasingly rare instances (due to the actual or perceived unfairness of it), this individual may also be responsible for issuing a sanctioning decision that addresses what should be done once the student has been found responsible. More often, the investigator determines responsibility and a separate decision-maker determines what sanction, if any, should apply.

Other models call for one or more investigators to prepare and issue a report that is provided to a separate decision-maker or decision-making body (e.g. a hearing panel composed of faculty, staff, and/or students who have been trained to adjudicate student sexual misconduct cases) that determines whether the student violated institutional policy. This person or body often then issues a sanctioning decision as well.

For purposes of the STARRSA Program, the most critical student conduct professional is the person or body that oversees the sanctioning phase of the student conduct process and that is capable of referring a student to a STARRSA Program. The sanctioning phase of the student conduct process should be understood as the period in which a student conduct professional (or body thereof) determines what the outcome or consequence will be for a student's misbehavior. The resulting outcome or consequence is often referred to as a sanction. A typical sanction for student sexual misconduct includes one or more elements. Some elements may be mandatory, whereas others may be issued as voluntary recommendations. For example, a student may be suspended for one year (mandatory) and encouraged to undergo counseling (voluntary). Typical elements of a sanction for sexual misconduct include: no-contact orders; housing and class restrictions; educational interventions (e.g. readings, reflection papers, lectures, movie viewings); referrals to specialized training (e.g.

regarding consent, sexual harassment, Title IX or similar); periods of probation or suspension; and, when necessary, expulsion. Specialized treatment specifically designed to reduce the risk of reoffense is rarely, if ever, an element of standard sanctioning packages.[vi] Any referrals to treatment that do exist are generally to more generic forms of counseling or programs that were designed specifically for non-student offending populations (e.g. adults or juveniles who have been criminally adjudicated for a sex offense).

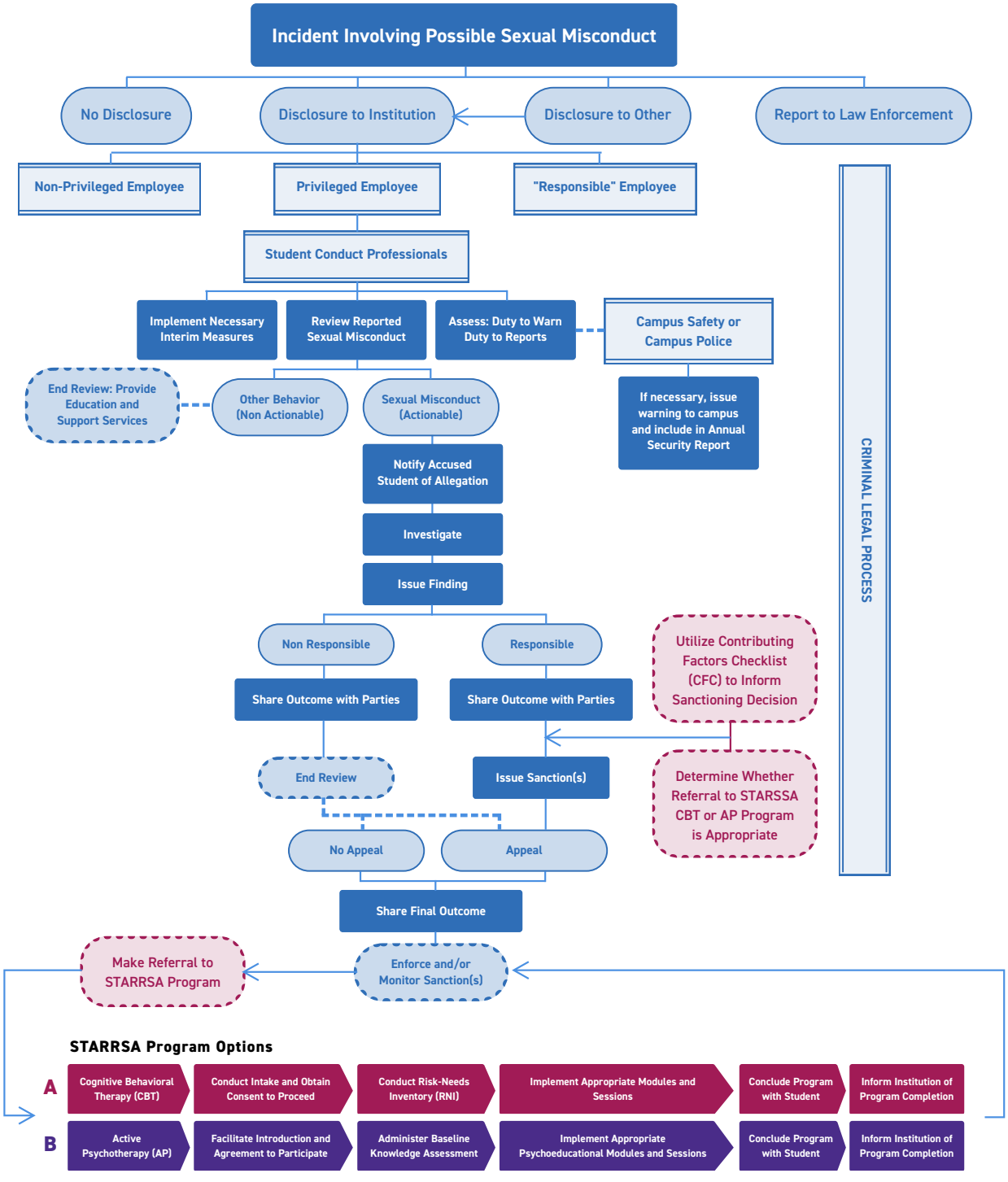
As defined by the STARRSA Program, the term sexual misconduct refers to a broad spectrum of behavior ranging from sexual harassment, sexually-inappropriate advances, stalking, and sexual pressure to battery that may itself range from groping and unwanted sexual touch to aggravated rape. All such behaviors are concerning, but not all will warrant suspension or expulsion. Likewise, not all are criminal in nature. Sexual harassment, for example, is not typically a prosecutable criminal offense.
The legal system functions independently from college or university student conduct processes.
A report made to the institution generally does not create a report to the police, apart from any statistical compilation that may be required by the Clery Act. That decision is always left to the victim, unless state law or institutional protocol requires otherwise, e.g. in a matter involving an underage victim. Although student conduct professionals can and should have a close working relationship with local police and prosecutors, their responsibilities are distinct. Student conduct professionals enforce institutional policy, whereas local police and prosecutors enforce criminal law. Sometimes student behavior simultaneously violates institutional policy and criminal law. In those instances, a student may be subject to both institutional process and criminal procedure. This occurs most often when a student is accused of non-consensual sexual contact as defined by the applicable criminal jurisdiction and when the victim reports the crime to law enforcement. It is less common, although still possible, with non-contact offenses and when a victim does not agree to assist with the prosecution.

Regardless, student conduct professionals should always make victims aware of their right to report the offense to law enforcement at any point in the process. Moreover, they should cooperate with local police and prosecutors to share information when necessary and to withhold information as private when doing so is required by applicable law, guidance, or protocol. In some instances, this may require delaying the student conduct process until local police or prosecutors are done collecting evidence. Student conduct professionals have an ongoing duty, however, to complete the student conduct process expeditiously. This means they cannot, as a matter of routine, delay the student conduct process until the criminal legal process is complete. Throughout, we have emphasized the criticality of confidentiality with the CBT Program. More information about what could be expected or requested in that regard is provided on pages 41-42 and Appendix C.

Clinicians administering the STARRSA CBT Program must have a basic understanding of these complexities and distinctions. Successful implementation of the STARRSA CBT Program requires coordination with student conduct professionals and could potentially involve some communication with the police. In all instances, however, it is imperative for clinicians to know the limits and boundaries of any communication with a third party. Throughout, we have emphasized the criticality of confidentiality with the CBT Program. More information about what could be expected or requested in that regard is provided in the Appendix. It's equally important for clinicians to understand the process(es) as a whole and how the STARRSA CBT Program fits within them.

STUDENT CONDUCT PROCESS DIAGRAM

ILLUSTRATING 3-STEP UTILIZATION OF STARRSA PROGRAMS



1. It is always the victim/survivor's choice whether to file a report with local law enforcement. This choice exists before, during, and after any potential report to his/her college or university.
2. A criminal legal process regarding the alleged misconduct can occur before, during, or after any campus disciplinary process. The two processes operate independently.
3. This individual may also be designated and referred to as the institution's Title IX Coordinator or Deputy Title IX Coordinator to ensure compliance with applicable Title IX law and guidance.
4. Institutions have a responsibility to report specifc criminal offenses under the Clery Act. This obligation should be fulfilled throughout the process as necessary.
5. There are various methods for investigating and arriving at a factual determination regarding the reported behavior. This diagram does not address those variables.
6. The tern "sanction" refers to the items that must be completed and those that are issued as recommendations.

CREDIT: Wilgus, Koss, Lopez, Lamade & Prentky

FIGURE 1

The diagram shows the typical flow of a student conduct process involving sexual misconduct and how the STARRSA Program compliments it. It also shows the point at which a victim/survivor may report the incident to law enforcement and notes how a criminal legal process could occur before, during, or after a student conduct process at the victim/survivor's college or university. Student conduct processes can be complex and nuanced. Criminal legal process can be as well. No single flowchart will adequately explain every detail at one institution, much less all of them. Nevertheless, the diagram below highlights key points for clinicians to consider.

C. STARRSA's Contribution to Student Conduct Practice

The response to sexual misconduct on college campuses, for-the-most-part, has been two-fold, prevention-based programs and intervention programs for those found responsible. Although prevention-based programs are a necessary component of a comprehensive responsive to this problem, it does not appear that they have successfully decreased sexual misconduct. Current sanctioning options for student sexual misconduct are limited. Specialized treatment is not widely available, nor are tools to adequately assess the risks and needs of a given student. The STARRSA Program fills this gap by offering two independent, multi-faceted, multi-modal, empirically-based interventions. The STARRSA CBT Program is designed to treat a range of more serious sexual misconduct involving hands on contact and penetration, whereas the AP Program targets less serious sexual misconduct like stalking, harassment, sexual pressure, and instances where there appear to be a knowledge or social skills deficits. Both programs offer opportunities to appropriately assess the risk and needs of specific students and tailor the interventions accordingly.

The diagram above notes points at which student conduct professionals can utilize STARRSA products. The first opportunity arises after a student has been found responsible for sexual misconduct, yet before a sanctioning decision has been made. At that point, student conduct professionals can utilize STARRSA's Contributing Factors Checklist (CFC) to inform their sanctioning decision. The CFC is a checklist that guides student conduct professionals through characteristics associated with a propensity to commit sexual misconduct and sexual aggression. Although it cannot predict sexual aggression or tell an evaluator whether a student will engage in similar behavior in the future, the CFC provides an easy-to-reference checklist of factors to consider before making a final sanctioning decision.

The second opportunity arises when the sanctioning decision is being made. Should the student be referred to a STARRSA Program? If so, which program? Here again, the CFC can be useful. A large number of contributing factors present may reasonably cause a student conduct professional to believe a referral to the STARRSA CBT Program is warranted, whereas a smaller number of contributing factors present may direct them toward a referral to the STARRSA AP Program. Even more importantly, however, certain factors are **bolded**, reflecting greater concern from the standpoint of risk. The intention is to be bring these critical factors to the attention of the Student Conduct Professionals. Thus, even a smaller number of factors that includes one or more of particular concern may signal the need for the CBT Program. Either way, the STARRSA Program provides an empirically-informed programmatic option for mitigating the risk associated with re-commission of the sexual misconduct.

D. STARRSA's Parameters and Limitations

As noted at the outset, the STARRSA Program is exclusively concerned with the sanctioning phase of student conduct processes and how multi-modal, empirically-based treatment and psychoeducational interventions can reduce the likelihood that students who have been found responsible for sexual misconduct will engage in similar behavior in the future. STARRSA Programs provide no guidance or recommendations regarding the reporting, investigation, fact-finding, or appellate phases of the student conduct process. The STARRSA Programs also refrain from addressing the multitude of primary and secondary prevention strategies/programs currently being utilized on campuses nationwide. That is not to say that the STARRSA Program is unconcerned with them, or is, in any manner, a substitute for them. Those programs are simply beyond the scope of the STARRSA Program and a description of their application, nuance, and efficacy is well beyond the scope of this Manual. For additional information about prevention efforts or the reporting, investigation, fact-finding, or appellate phases of a student conduct process at a specific college or university, clinicians are encouraged to consult a student conduct professional at that institution.

A full description of the criminal legal processes is also beyond the scope of this Manual. For present purposes, clinicians must simply understand that a student who is found responsible for sexual misconduct at a college or university may also face criminal prosecution. On one hand, it's possible that a student who enters the STARRSA CBT Program may have already been found guilty of a criminal offense related to the same behavior/incident for which he or she is being referred to you by the college or university. In these instances, a clinician could be asked to provide an individual (e.g. a probation officer) with information about the student or the treatment s/he is undergoing. This should only be done, of course, with explicit written permission provided by the student, as it is not covered by the Informed Consent process envisioned by the STARRSA Program nor documented in the sample Informed Consent Agreement provided in the appropriate Appendix.

On the other hand, it is possible that a student who enters the STARRSA CBT Program may face current or future prosecution for his or her behavior. In this circumstance, a clinician could be asked to speak with police or prosecutors about the treatment or to opine about risk. Such requests could be made informally or as formal interview requests or subpoenas. In all instances, however, the therapeutic process is confidential and clinicians are not permitted to disclose information to third parties without explicit written permission from their client. If a release from the client is sought, the potential consequences of signing such a release must be discussed in advance. For more information about what could be requested from a clinician implementing the STARRSA CBT Program and how to respond to various requests, please see the appropriate Appendix.

E. Basic Premises of the STARRSA Project

The most basic assumption is that campus administrators are committed and actively engaged in all facets of improving and refining the prevention and response strategies related to student sexual misconduct. This section expands on that general premise by enumerating other several other basic assumptions.

First, the Program assumes that campus administrators have sufficient training in their fields to properly

perform their assigned roles. Student conduct professionals, for example, must understand the elements of procedural due process and what is constitutionally and/or contractually required to protect student rights. Although they need not be attorneys, they must have working knowledge of the legal system and, most importantly, how the criminal legal process interacts with their own. They must understand relevant reporting requirements and be capable of performing all functions in accordance with applicable law, guidance, and institutional protocol. The STARRSA Program also presumes that most student conduct professionals are members of appropriate professional organizations (e.g. the Association for Student Conduct Administration (ASCA), the Association for Title IX Administrators (ATIXA), or others) and that they participate in professional development that allows them to stay current with developing trends and best practice. The same presumption holds true for other campus administrators, including campus clinicians who may be asked to administer the STARRSA CBT Program and who ought to be appropriately involved with professional organizations of their own to ensure their work remains compliant and effective.

Second, the Program assumes that any and all professionals associated with a student sexual misconduct case, including student conduct professionals, clinicians, victim advocates, and others, will abide by the privacy or confidentiality regulations associated with their role. For example, student conduct professionals are expected to understand FERPA, the federal law that protects the privacy of student education records, including those involving student conduct processes. Clinicians associated with the project are expected to protect the confidential relationship between clinician and client. In instances where those obligations may initially appear in conflict (e.g. when referring a student to or from the STARRSA CBT Program), professionals are expected to collaborate in a manner that respects their legal obligations and professional boundaries, while honoring a student's decision to voluntarily participate in a STARRSA program. Active, informed, and voluntary student consent is a fundamental prerequisite for effective clinical intervention.

The Program assumes that professionals associated with these matters will comply with any mandatory reporting laws, regulations, guidance documents, or ethical standards to which they are beholden. The most obvious example involves States that require various professionals or institutions to report any known or suspected sexual abuse of a minor.

Third, the Program assumes that participating institutions comply with all applicable reporting requirements, including, but not limited to, those relating to the Clery Act, those involving child abuse, elder abuse, or immediate threats to the safety of a reasonably identifiable individual, and those unique to the city or state in which the institution is located. This assumption applies to clinicians administering the STARRSA Program as well. For information about mandatory reporting within the STARRSA Program, see guidance provided in the appropriate Appendix.

Fourth, the Program assumes that every college or university has a written statement that complies with the Clery Act regarding the working relationship between campus security personnel and State/local police agencies, including any agreements between the institution and the agencies regarding the investigation of alleged criminal offenses. The STARRSA Program further assumes that student conduct professionals maintain positive working relationships with members of police agencies (whether on campus, off-campus, or both)

so they can collaboratively refer students to law enforcement when appropriate and collaborate with law enforcement on shared matters. As noted above, this is particularly important when dealing with matters that violate both institutional policy and criminal law and, importantly, when the victim/survivor chooses to file a police report.

Fifth, the Program assumes that student conduct professionals are aware of the public registry of sex offenders on the National Sex Offender Public Website (NSOPW) and that they check the NSOPW to confirm whether or not a student who has been found responsible for sexual misconduct has been found guilty for any previous sex offense. Likewise, the STARRSA Program assumes campus admissions offices are aware of the NSOPW and that they check it if they have any reason to believe a student may be required to register as a sex offender. If a student is known to be a registered sex offender by the referring institution, the institution should make that information known to the treating clinician before the first session of the CBT Program. If a clinician has any doubts, however, they may request additional publicly available information from the institution or independently check the NSOPW. This step is discussed in further detail elsewhere (see the appropriate Appendix).

Sixth, ideally, all providers using either STARRSA program or any products associated with these programs should receive appropriate training. The Manual serves as a resource for those who have been trained, but is not a substitute for training. Training, for example, draws important distinctions between the CBT and AP Programs, including the fact that the CBT Program is confidential while the AP Program is not. Training also provides an opportunity for participants to ask questions, work through case scenarios, and develop implementation strategies with colleagues.

Finally, the Program assumes voluntary participation by both the student and the referring institution no institution should be forced to make a STARRSA Program available to students, and no student should be compelled or coerced to participate in a STARRSA Program, nor threatened with expulsion for failure to participate or failure to complete the Program. Maximizing program effectiveness is achieved when the student enters the Program under their own volition, aware of the benefits and drawbacks. If, at any time, a provider becomes aware that a student feels forced or compelled to participate, the provider should revisit the informed consent document signed at the outset and discuss: a) the voluntary nature of participation, and b) the process for terminating the relationship and referring the student back to the student conduct office if the student wishes. Additional detail about this process is in the appropriate Appendix.

OVERVIEW OF STARRSA PROGRAM DEVELOPMENT

The development of the STARRSA program consists of two phases as outlined in Figure 2 and summary below.

For additional details, please see Lamade, Lopez, Koss, Prentky, & Brereton (2018). Developing and implementing a treatment program for college students found responsible for sexual misconduct. *Journal of Aggression, Conflict and Peace Research. Special Issue: Multidisciplinary Applications to Campus Safety and Sexual Violence Prevention, 10*, 134-144.

PHASE 1

Phase 1 of Program Development focused on assembling data from the extant literatures on campus sexual assault and on adjudicated juvenile and adult sex offenders, as well as survey data gathered for this project from male and female college students. Since there were no formal risk assessment procedures for the population of college students, and there certainly were no empirically-driven treatment programs designed and tested for these sanctioned college students, it was necessary to fill in many of the gaps by augmenting the empirical literature on adjudicated offenders and the empirical literature on college students with survey data that sought to target these gaps.

We illustrate below how many of these risk factors converge on college campuses, making the campus environment a fertile ground for potential sexual misconduct.

Core Converging Risk Factors: The Perfect Risk Storm

College students are a high-risk group for sexual assault and sexual misconduct (Koss, 1988; Kilpatrick & McCauley, 2009). The high incidence of sexual misconduct on college campuses is neither surprising nor is it new. Kanin (Kanin, 1957; Kirkpatrick & Kanin, 1957) documented that a significant proportion of college women (20-25%) reported being sexually coerced and forced over a half century ago. Abbey (1991) noted a quarter century ago an extensive literature documenting the high rates of sexual misconduct on college campuses. Berkowitz (1992) also noted that a substantial proportion of college women are at risk of becoming victims of sexual misconduct on campus. What was well known decades ago remains true today. The explanation would

seem to be best captured by the remarkable number of converging risk factors that forge something of a perfect storm for sexual misconduct on college campuses.

1. College Students / Social Culture: College students are predominantly young ("emerging") adults, only shortly beyond adolescence. Sexuality and sexual exploration are not merely a primary focus, it is normative. Freed from parental constraints and with abundant opportunities for social life, these "emerging" young adults are magnetically drawn to a social culture that promotes, and indeed places emphasis on, informal, casual "dating" ("hooking-up," "friends with benefits"). A few (most often young men) are rape-prone; Abbey (1991) noted that, "More than 80% of the rapes that occur on college campuses are committed by someone with whom the victim is acquainted; approximately 50% are committed on dates," (p.165).

2. Victim Access: In addition to partying, there are numerous opportunities for easy access to potential victims; many of these opportunities facilitate socializing – from meeting in classes to sports, going to the gym, meeting in residence halls, at clubs, at social gatherings, at student hang-outs, or simply walking across campus.

3. Alcohol & Drugs: Alcohol is ever-present on campus. The critical role of alcohol as a disinhibitor has been documented numerous times (e.g., Abbey, Jacques-Tiura, & Lebreton, 2011; Abbey, Parkhill, Jacques-Tiura, and Saenz, 2009; Abbey, Wegner, Pierce, and Jacques-Tiura, 2012; Adams-Curtis & Forbes, 2004; Jacques-Tiura, Abbey, Parkhill, and Zawacki, 2007; Parkhill & Abbey, 2008; Purdie, Abbey, & Jacques-Tiura, 2010; Schwartz & Leggett, 1999; Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994). Moreover, drugs are easy to come by, including drugs used to facilitate rape by inducing anterograde amnesia, such as the benzodiazepine Rohypnol and the central nervous system depressant GHB (gamma-hydroxybutyrate), as well as many other drugs, such as ketamine (Ketalar), methaqualone, and zolpidem (Ambien).

4. Developmental Immaturity of the Respondents: The vast majority of undergraduate men are in the age range of 18 to 25; most are themselves still in adolescence, with the same psychosocial, psychosexual, cognitive, and neuro-cognitive immaturity of juveniles, with all of the predictable sequelae of risk taking, impulsivity, poor decision-making, increased proneness to disregarding or breaking the law, and intense, often poorly-managed emotions. The combination of poor decision-making, insensitivity to risk, poorly managed emotions, peer pressure, and the ubiquitous disinhibiting agent alcohol are a bad combination.

5. Coercion-Supporting Peer Groups: Groups that support sexual coercion, or that promote the message of sexual entitlement and the end goal, beyond all else, of "scoring" (having sex), can be an obvious risk factor for sexual misconduct. These are the students that are most likely to espouse and condone rape-supportive attitudes, minimization and trivialization of sexual misconduct, and attitudes characterized by hostile and negative masculinity. The influence of

these students can be highly persuasive for those students that may not hold such attitudes but value group acceptance and "having a good time" over momentary hesitance that "it isn't right." At that point, a little alcohol is all that is needed to lower their inhibitions. Although there appears to be an over-representation of male athletes and fraternity members among those alleged to have committed sexual misconduct, we are talking about a relatively small subgroup of fraternity members and athletes that clearly support sexual coercion.

6. Victim Pool: As with undergraduate men, undergraduate women are in the same age group – emerging adults. Although typically more mature than the men, they, nevertheless, tend to be naïve and trusting, with limited dating and relationship experience. College men do not raise instinctive red flags of a threat; they are just "guys" out for a good time (most are). The women too are just looking for a good time.

7. The Setting: Perhaps with the exception of inner-city campuses, colleges are seen as generally safe, protected environments, free from dangerous "elements," and generally are not "threat-arousing" locations. This perceived sense of "immunity" is coupled with the impression that *since everyone is doing "it" (partying), it can't be wrong or risky*.

Gathering Data

Feedback from our consultants, combined with the relevant literature, was used to inform the second step of Phase I, data collection. We gathered data from current college students, current campus administrators, and university stakeholders. It was through the process of gathering data from campus administrators and university stakeholders that the need for a psychoeducation variant of our intended therapy program was revealed.

Data from current students was collected by surveys and focus groups. The survey designed for the male students was a compilation of many individual scales, primarily scales well known in the field, and a few developed in-house. The scales chosen inquired about personality traits, including narcissism, history of delinquency, history of alcohol and drug use, history of sexual experiences and pornography use, and attachment. The female survey, by contrast, focused on campus climate and safety, reporting sexual misconduct and reasons for not reporting and history of victimization. These data were used to inform the development of the CBT program and subsequently, the AP Program. Student focus groups were run, aimed at ascertaining students' reactions and identification of barriers to an intervention for students found responsible.

For details about the student focus groups, please see:

Schaaf, Lamade, Burgess, Koss, Lopez, & Prentky, R. (in press). Student views on campus sexual assault. *Journal of American College Health*. (DOI:10.1080/07448481.2018.1500476.).

Lastly, we developed pilot training materials and completed a series of trainings. It was through this process

of pilot training that we made note of barriers, obstacles, and challenges that were both logistical and substantive with respect to both the development and implementation of the CBT program (the AP Program came later). The substantive input took the form of strong recommendations from various schools we visited about their urgent needs, such as the diversity of sexual misconduct (not restricting it to the more extreme forms of misconduct) and diversity with respect to the students that the program was intended for (e.g., students found responsible for hazing, bullying, and/ or assaulting LBQTQ students).

PHASE II

Phase II consisted of piloting the STARRSA programs at colleges and universities for two semesters. Feedback was compiled from these pilot sites through surveys and telephone interviews. This consisted of feedback pertaining to logistical and implementation concerns, staff opinions, feedback about STARRSA materials, and feedback from clinicians and facilitators who directly implemented the programs. Additionally, feedback from the Department of Justice's review of the pilot materials was addressed. The CBT and AP Manuals and materials were finalized accordingly.

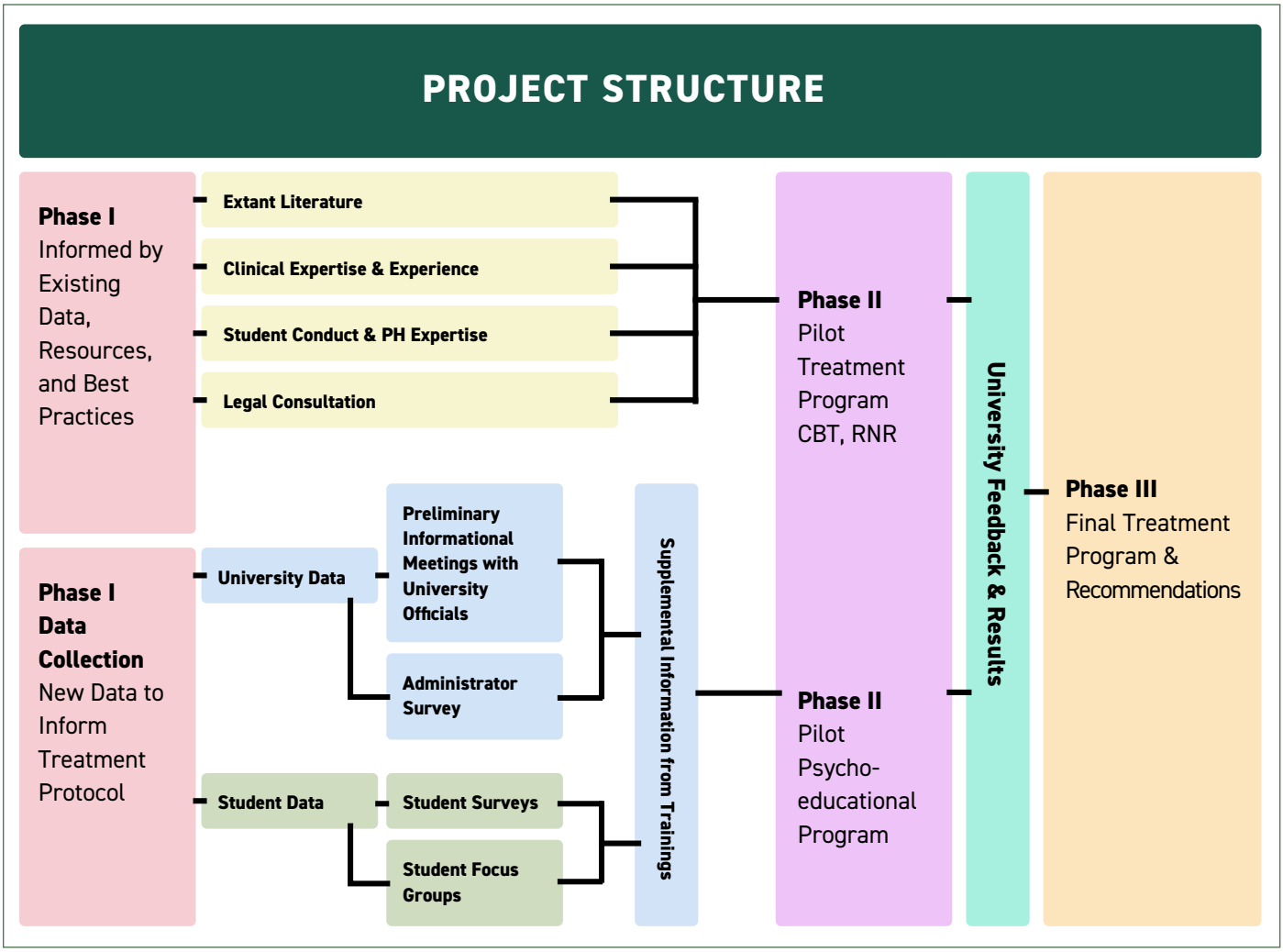


FIGURE 2

CORE FEATURES OF THE STARRSA CBT PROGRAM

There are four fundamental features that are embedded in both programs to increase effectiveness and maximize usefulness while maintaining fidelity.

First: Utilization of known population characteristics to facilitate intervention. This population (i.e., college students) constitutes what Arnett termed "emerging adulthood" (Arnett, 2000). College students are at a very distinct, well-understood developmental stage, not far beyond adolescence, that must inform and guide program development. What is taken for granted and understood to be normative – impulsivity, risk-taking, poor decision-making, peer dependence, emotional volatility, social and interpersonal experimentation and immaturity, must be factored, both as normative, mentioned above, as well as potentially contributory to their misconduct.

Second: Adherence to an RNR model. RNR (Risk-Needs-Responsivity) dictates an initial assessment of **risk** factors that serve as ***needs*** requiring attention in order to mitigate the risk. **Responsivity** refers to those considerations for each student that may facilitate or hinder their progress (e.g., sensitivity to a student's learning style, gender, and sexual identity or orientation) Risk factors are subsumed within modules, with each module focusing on a different domain of needs. The goal is not to walk through all of the modules. The task is to select, based on the Module 1 intake, those modules or sessions within modules that are most appropriate for the student's **needs**.

Third: Today's college students are mostly Generation Z with very distinct generational preferences for face-to-face communication, videos, YouTube, and Snapchat while eschewing Facebook and email (the latter is antiquated – for "adults"). We have tried to adapt by providing many optional resources that the facilitator or therapist may choose from if appropriate (e.g., YouTube, Ted Talks, and videos), as well as PowerPoint presentations, and experiential exercises. These resources are intended to increase student engagement and facilitate change in a relatively brief amount of time.

The **fourth** feature maximizes flexibility in order to accommodate the broad range of sexual misconduct encountered on college campuses, the diverse treatment needs and responsivity of students, and the varied student conduct processes within which these STARRSA programs are embedded. Given that the thousands of colleges and universities across the country have quite different policies and procedures, in order for an intervention such as this to be widely implemented, it must be flexible enough to work within diverse systems, frameworks, and student conduct processes.

STARRSA CBT PROGRAM

The STARRSA CBT program is designed to facilitate quality assessments and targeted treatment interventions. The STARRSA CBT manual designed to help guide qualified clinicians who may be new to treating students found responsible for campus sexual misconduct, as well as providing many useful resources for those with more experience as well.

GETTING STARTED: PREPARING TO IMPLEMENTING THE STARRSA CBT PROGRAM

Clinician Qualifications

We recommend that clinicians who implement the STARRSA CBT Program have a minimum of a Master's degree in counseling, social work or a related field, and be **independently licensed** mental health professionals with training in cognitive behavioral therapy. In addition to training in Cognitive Behavioral Therapy (CBT), clinicians should understand the RNR (Risk-Needs-Responsivity) framework and how this is embedded in the components of this program to increase effectiveness, maximize usefulness while maintaining program integrity and, efficacy. Although we recognize it may be unrealistic, we recommend clinicians have training in working with clients referred for treatment. Graduate students in training or conditionally licensed clinicians may provide STARRSA as long as they have appropriate training and supervision.

Clinician Preparation

Clinicians that use this program should be familiar with the clinical and empirical literature addressing campus sexual misconduct, as well as the policies and procedures for the investigation and sanctioning of misconduct at the school. Clinicians should also be acquainted with state, federal, and professional regulations governing confidentiality and privileged communication between therapists and their student clients. Clinicians are bound by federal HIPAA rules related to the security of protected health information and therefore must understand HIPAA rules. Those that are employed at a college or university are also bound by the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99), the federal law that protects the privacy of student education records.

Who is the client? In a forensic evaluation, the client is the referral agent, typically the attorney. In this case, although the referral is from an institution, the therapist's client is still the student. It is for this reason that we recommend always referring to the student as your "client." The student/client holds privilege and confidentiality must be guaranteed. The context, however, dictates that the institution will likely want some confirmation of treatment compliance and completion. Once again, what the referring institution expects will vary considerably.

Whatever the communication with the institution is, however, the client must be fully informed and accept the arrangement in advance of treatment. It is a core part of Informed Consent. Please see the Appendix C regarding informed consent, confidentiality and records.

The following is recommended in preparation, prior to administering the STARRSA CBT program.

- Review this manual in its entirety.
- Access training resources
    - Attend an in-person training. Contact Raina Lamade, Ph.D. for information.
    - Review the Training Slides in Appendix A.
    - Reviews the Supplemental training video on the Flash drive.

Point of Entry: Understanding the referral process to the STARRSA CBT program.

It is highly unlikely that a student will enter the CBT Program entirely of their own volition. Most, if not all, will be referred to the program by an institution that has found them responsible for sexual misconduct. Although the CBT Program makes clear that students should never be forced to undergo treatment, the situational context makes it impossible to ignore the reality that a student's decision to participate is not entirely "voluntary" either. To effectuate a meaningfully voluntary referral to treatment, however, institutions may utilize at least two methods. The first follows the standard flow of student conduct processes discussed above and simply inserts a referral to the CBT Program as a voluntary component of the sanctioning package. In those cases, the institution will likely monitor whether the student completes treatment, but will not require it and will not penalize the student in any way for failure to complete treatment. The second method involves what is most easily described as a diversionary process that permits a student who has been found responsible for sexual misconduct to resolve the matter by entering into a voluntary resolution agreement with the institution. If the student successfully fulfills all aspects of the agreement, the matter can be considered resolved and the student may return in good standing to the institution. If a student fails to complete one or more aspects of the agreement, the matter can be referred back to a traditional sanctioning process in which the institution issues and enforces any sanctions it deems appropriate for the behavior. The latter may not include referral to a STARRSA program, although it could still conceivably include a recommendation regarding the institution's desire for the student to complete some form of intervention.

Challenges to Anticipate at the Beginning

If the student is firmly committed to returning to the institution – as opposed to transferring to another school – there is an inevitable conundrum of what can only be construed by the student as, at least to some extent, a mandate to comply with the referral or risk being expelled. Because we are of the realistic conviction that most students will not approach referral to treatment cheerfully or enthusiastically, we strongly encourage that all ambivalent or hesitant or angry students be encouraged to attend a simple "information session" with a therapist to discuss all of the ramifications of treatment (e.g., what the student might anticipate, what the benefits might be, what the drawbacks might be). This "***information session***" should be open, honest and forthright, emphasizing to the student that it is merely a "meet-and-greet" and not a commitment to participate, just an opportunity to learn about what the experience will entail. It also provides students the opportunity to see if they feel comfortable working with the provider. We recommend, whenever possible, that a range of providers who can administer these programs be made available for students. Provider / client "fit" is important; it is part of "responsibility."

Regardless of referral method, therapists **must** plan a thorough discussion with the referred student in the initial session that includes the confidential nature of the client/therapist relationship, the concept of privilege, and the details of any reporting requirements for the therapist set forth by the institution.

See Appendix C section in this Manual for further discussion

As noted , whether the student is asked to engage in either program, the student most likely will be leery, distrustful, bitter, contentious or downright antagonistic. Students are unlikely to eagerly "volunteer." The challenges to treatment engagement and motivation are similar to those found in any treatment-mandated population (e.g., criminal justice) and motivation and willingness to engage in the process may need to be confronted head-on and indeed be re-addressed throughout the program. Thus, at the outset, students may be highly resistant, and the need to incorporate motivational interviewing may be paramount. R*emember, the student did not "ask" to be in your office, and more often than not, the student will not believe that he / she belongs there.* Giving the student ample space and time to discuss their ambivalence or resistance or anger forthrightly is likely to improve motivation.

See Appendices A, C, D, and Module 1 for further information

Another challenge at the time of the referral potentially related to treatment engagement for a few students may be the gender of the clinician. We only discuss gender as a potential issue in Module 5 (negative masculinity). To be clear, we do not consider clinician gender an insurmountable obstacle to engagement. Moreover, we recognize that clinicians may be few in number and gender choice may not be an option. In Module 5 we simply highlight an issue that may need to be addressed in session (e.g., female clinicians addressing negative masculinity with male clients).

As stated above, we strongly recommend that students in the CBT Program, be referred to as clients. The use of the word client reflects the need to treat students with the same respect afforded all other clients, *and not over*

focus on their "status" as students referred because of sexual misconduct. For *all* students, assigned to either AP or CBT, the mere referral "to see a shrink" can be highly stigmatizing when "the word gets out." The deleterious impact of stigmatization around race, ethnicity, mental illness, religion, and, of course, gender and sexuality. has been explored in voluminous sociological, epidemiological, and psychological treatises. Apprehension about "what my friends will say" or "what if the girls find out" (assuming the student is male and heterosexual) must again be addressed openly and forthrightly. A male student's experiences – and concerns – may well include "supportive friends" impugning, belittling, or denigrating not just the "need" but the entire "process" (AP or CBT) and, in so doing, pushing back against two primary goals of taking responsibility and appreciating wrong doing. Thus, what "the guys and girls will think" is not to be dismissed; it may be at the core of what needs to be addressed at the beginning.

COMPONENTS OF THE TREATMENT PROGRAM

The treatment manual includes:

1. Assessment materials
    - Risk Needs Inventory - The Risk and Needs Inventory (RNI) is designed to facilitate the clinical assessment of dynamic risk factors that have been identified in the empirical and clinical literature as associated with the risk of sexual misconduct among college students, juvenile, and adult sex offending, and sex offense recidivism. See Appendix E for a full description.
    - RNI Brief Assessment and Interview Guide
2. Document that links the RNI items to specific treatment modules
3. Informed Consent template
4. Treatment Completion Summary Template Form
5. A guide template for each session includes recommended content, materials, and resources.
    - Appendices to the manual include additional resources, including videos, activities, and experiential exercises tailored for this program.

A flash drive containing:

1. The treatment manual
2. RNI digital version
3. STARRSA Videos
4. Electronic versions of materials (e.g., CERTS hand out, informed consent sample, etc.)
5. A "Hard Copy" (PDF) of the Powerpoint Training Slides
6. A supplemental training video

MODULE FORMAT

Each Module contains multiple sessions that contain the following:

CHECK IN: General check in and specific follow ups from the prior week, brief review of any Out-of-Session Assignments.

SESSION GOALS: Goals for each session.

OBJECTIVES: Objectives associated with the session goals.

SUGGESTED SESSION CONTENT: Content and focused themes.

POSSIBLE ACTIVITIES: Activities that may be useful during treatment are described in each session. Additional resources that may be used in session or assigned as out of session assignments, such as STARRSA and other videos, experiential exercises and additional multimedia resources can be found in the Activities and Materials Section of the manual (Appendix D).

POSSIBLE OUT-OF-SESSION ASSIGNMENTS: Out-of-session assignments (OSAs) are strongly recommended to facilitate and reinforce therapy goals. Assignment possibilities, such as relevant multimedia, exercises, and activities, are outlined in Appendix D. It is recommended that the client document his or her reactions to the assignments in writing and discuss them in the next session. Such assignments may include the following:

- Learning more about sexual misconduct: antecedents, consequences and the impact on victims. Activities that may increase the client's appreciation of how sexual misconduct impacts others include multimedia resources.
- Practicing specific problem-solving strategies to facilitate good decision-making.
- Practicing impulse and emotion regulation exercises.

CHECK OUT (5-10 MIN): Check out concludes the session and provides an opportunity to briefly reinforce key points.

APPENDICES

Appendix A STARRSA Program Training Slides

Appendix B Student Identity and Diversity

Appendix C Informed Consent Packet

Appendix D The Guide to Risk, Needs, and Interventions in the Treatment Manual
(Provides a link between the RNI items and modules).

Appendix E Risk Needs Inventory

- Risk Needs Inventory Face Sheet
- Risk Needs Inventory Manual
- Brief Assessment and Interview Guide for the RNI

Appendix F Activities and Materials
**All activities and materials can be found in this section or on the flash drives.*

Activities and Materials - Handouts and Worksheets

- Victim Impact Vignettes
- Attitudes and Beliefs Worksheet (Cognitive Distortions Worksheet)
- Experiential Exercises list (see flash drive for exercises)
- CERTS Handout (see flash drive and hard copies in packet)
- My Plan For Success
- Son It's OK if You Don't Get Laid Tonight
- Link to: How 7 Things That Have Nothing to do With Rape Perfectly Illustrate the Concept of Consent
- Sex and the Law Handout

PowerPoints

- Sex and the Law
- Changing Times
- Drugs and Sexual Misconduct
- Groupthink
- Negative Masculinity
- Sociocultural Context of Rape

Multimedia Resources

- All Program Videos by Treatment Modules

- STARRSA Program video descriptions including intro and outro narrations
  **Note: The clinician may decide whether they want to play the outro or review this with the client directly.*
  ****STARRSA Program Videos are recommended to be used in session only.***
- Additional multimedia resources

Appendix G Sample Treatment Completion Summary

Appendix H Adjunctive Treatment Interventions

Appendix I Sexual Misconduct Contributing Factors Checklist (CFC)

Appendix J Resources for Service Providers
- Factsheets
- Organizational websites
- Guidelines

Bibliography

ADMINISTERING THE STARRSA CBT

PREPARATION PRIOR TO ADMINISTERING

1. Review this manual in its entirety including clinician qualifications.
2. Attend an in-person training. Contact Raina Lamade, Ph.D. for information.
3. Review the training STARRSA Training Slides in Appendix A
4. Review the Supplemental training video on the STARRSA Flash drive.
5. Review the following section on additional guidance

ADDITIONAL GUIDANCE ON ADMINISTERING

1.Parameters of Confidentiality

Prior to the first session, clinicians must establish the parameters of therapist-client confidentiality by communicating with the referring school. The therapist must be clear about the reasons for the referral, the school's expectations about reporting attendance and completion of therapy, and any other communications that might affect confidentiality. Whatever arrangements have been agreed upon must be communicated fully to the student as part of Informed Consent.

Importantly, however, schools have FERPA (Family Educational Rights and Privacy Act) guidelines to follow just as the clinician has HIPAA (Health Insurance Portability and Accountability Act) guidelines to adhere to.

Any information that the clinician shares with the school must be considered in the context of what is minimally necessary to demonstrate participation in treatment, as well as what could be clinically contraindicated to therapeutic engagement or undermine effectiveness of treatment. It is recommended that confidentiality and privilege be upheld and that the only information communicated to the college or university by the therapist is a simple yes-no response about client attendance and completion.

Despite the obvious concerns about FERPA guidelines, clinicians will need to have reasonably detailed information from the school to fully inform the client prior to presenting him/her with a statement of Informed Consent. For example, if the clinician is a provider at the college/university the prospective client might want to know:

1. What will happen if he/she does not engage in, or complete treatment?
2. Who at the university will have access to his/her progress or completion reports?
3. Will any of these treatment-related documents become part of his/her record?
4. How will these treatment-related documents be stored and protected?
5. For how long will these documents be retained?
6. With whom might these documents be shared outside of the institution?
7. Are there any other foreseeable "uses" for these documents in the future?

The bottom line is that this negotiation of the school's expectations for feedback versus the student's right to confidentiality must be successfully addressed on a case-by-case basis.

For the clinician receiving a referral, however, this may reduce to simple clarity of who is my client? In a *forensic* evaluation, the client is the referral agent, typically the attorney. For the clinician, however, the student is **not** a forensic referral and should not be considered as such. The client holds privilege and confidentiality must be guaranteed. The context, however, dictates that confidentiality is "*partial*" (i.e., feedback about the course of treatment may be shared with student conduct officers and such feedback may be determinative in allowing the student to return to campus). Even this caveat, however, differs by policy from one school to another. We were told quite clearly at one school that all they wanted to hear from the clinician is that "the student is good to go."

ADMINISTERING

1.Obtaining Relevant and Necessary Information

Information About the Client From Records and Referral Sources

Clinicians should obtain as much information as possible about the sexual misconduct prior to the first session. The school should provide clinicians with all available information about incidents of sexual misconduct, including – if possible – a copy of the investigative report or an executive summary thereof, and a copy of the Contributing Factor Checklist (CFC). The following are examples of records and collateral sources to consider.

- File information pertaining to the misconduct.
- Contributing Factor Checklist (CFC).
- College academic records – if relevant and permissible under FERPA.

- College records of any other rule or conduct violations.
- Collateral source information provided with appropriate releases of information, e.g., prior therapy or mental health assessments.
- Relevant psychological tests, if indicated.
- Risk & Needs Inventory (RNI) and clinical risk and needs interview.

When the student is suspended, the school, or a representative of that institution, may not be the original point of contact. The clinician will need to obtain a release from the student/client to speak with the appropriate party at the institution in order to secure the necessary information. This situation may occur, for example, if the student was told to seek treatment on their own.

2. Orient the Client to Assessment and Treatment

The clinician typically orients the student by reviewing the assessment process, expectations of treatment, and limits to confidentiality. The clinician obtains signed informed consent and reviews expectations of the university, including informing the university about treatment compliance and completion. **Please see the Appendix C regarding informed consent.**

During the first session, the client should be encouraged to view treatment as an opportunity to learn and grow, not as a form of punishment. Mild resistance to outright hostility should be expected. Recognizing resistance and anger, permitting its expression, and discussing it forthrightly takes the edge off and is the portal to treatment. Pointing out that the client is not the only one that was "hurt" by what happened keeps the purpose of treatment in focus.

3. Assessment and Treatment Planning

The initial treatment assessment, including using the RNI (Risk-Needs-Inventory) is intended to provide necessary information for individualized treatment planning by identifying relevant dynamic risk factors, treatment needs, individual strengths, and positive social supports. In addition to pinpointing risk- relevant treatment targets, the intake assessment should identify mental health needs, if present, and any treatment-related considerations, such as ethnic or cultural factors and child maltreatment histories.

The assessment process provides an opportunity for the clinician and the student to become "acquainted." The intake interview begins the process of treatment engagement and helps to build rapport. In the spirit of motivational interviewing, the intake allows clinicians to frame treatment as an opportunity for self-examination rather than punishment, which can empower the client and enhance motivation to change. The intake can also permit clinicians to identify any potential barriers to treatment and to assess potential exclusionary criteria (e.g., signs of major mental illness, severe personality disorders, etc.).

Effective treatment interventions begin with an assessment aimed at identifying risk relevant treatment needs in order to individualize the therapeutic intervention. The goal is simple – recognize the time-limited nature of treatment by targeting and addressing only those risk factors deemed to be related to the misconduct. As noted above, all other legitimate areas requiring intervention may need to be referred out. This program includes a semi-structured interview corresponding to the RNI-TV to provide an in-depth assessment of the client's dynamic risk factors (i.e., those risk factors that can be changed) to help with treatment planning. *The use of this interview is strictly elective. The clinician may wish to conduct her/his own intake interview.*

Treatment Planning

Coupled with the intake interview and the completion of the RNI, the clinician determines the most misconduct-relevant risk factors and related treatment need factors. This information is used to select the corresponding modules and sessions within those modules. A guide is provided in Appendix D that links individual RNI items to places within each Module and each session within the Module. The link is between a risk factor and programmatic interventions that address that factor. Although determining the student's risk and needs are the driving principle in targeting which modules and sessions to use with the client, this should be considered in the larger context of the clinician's overall understanding of the client (i.e., sound clinical judgment that considers risk and needs in the context of the client's history and current presentation).

Once the initial Treatment Assessment is complete, findings are reviewed with the client and treatment recommendations are discussed. In keeping with the responsivity principle, discussion can provide input about the client's receptivity to different activities and help identify the materials and modalities that the client may be most receptive to. It is recommended that the client be invited to participate in and contribute to his/her own treatment plan. Motivational enhancement strategies will hopefully facilitate and enhance the therapeutic relationship. Although session frequency will vary depending on client need, the CBT Program was geared to 10-15 weeks depending on risk and needs. As noted above, however, the number of sessions required may be less, depending on the severity of the misconduct, the scope of identified needs, and the investment of the student.

Treatment Plan

Following the assessment, a written treatment plan outlining individualized treatment goals should be discussed and signed by the client and the clinician. The plan should outline treatment expectations, such as the frequency and length of sessions, active participation, and thoughtfully executed out-of-session assignments. Treatment plans should be updated as needed (e.g., in response to significant life events or changes).

4. Progress and Treatment Completion Assessments

Ongoing interventions are most effective when informed by re-assessments, using the RNI that evaluate the extent to which the interventions have been successful, and what modifications, if any, are needed. To facilitate this, we recommend progress assessments to evaluate and update risk factors and treatment needs.

By using a continuous risk and needs assessment process, the clinician should be able to design, and re-design, an individually tailored therapeutic intervention program delivered in a manner that promotes a positive treatment response.

When it has been determined that treatment goals have been met, the clinician should write a treatment completion summary that overviews progress that the client has made. This summary is shared and discussed with the client. If the clinician concludes that the client has not satisfactorily completed treatment, this must be discussed with the student, as the school may need to be so informed.

Referrals

Initial assessment results, subsequent treatment, or treatment assessment findings may indicate the need for additional therapeutic supports beyond the scope of this treatment program. Such support may be provided by the clinician if she/he is appropriately trained. Otherwise, as noted above, a referral should be made, or at the very least, the need for such a referral should be documented. Examples of needs for referrals may include:

- Substance abuse treatment
- Trauma-focused therapy / PTSD symptoms
- Acute or Generalized Anxiety
- Depression
- General psychiatric referral for diagnosis and medication if appropriate
- Issues related to identity

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MODULE 1

Orientation, Assessment and Psychoeducational Planning

Orientation, Assessment & Treatment Planning

SESSION 1: **ORIENTATION & ASSESSMENT**

Session Goals

- Orient the client to therapy.
- Describe and set the framework for treatment.
- Develop rapport and engage client.
- Begin the Initial Assessment.

Session Objectives

- Briefly describe the goals of the treatment program.
- Provide information to ensure informed consent, review and obtain consent.
- Begin the initial intake assessment.
- At the end of the session, the client should have a clear understanding of the purpose and goals of treatment, expectations of the treatment process, confidentiality and the standard limits, what information about compliance and completion will be shared with the school, and any policies of the clinician.

→ Suggested Session Content

- **Introductions and establishing the therapeutic contract**

- **Inquire as to the client's understanding of why he or she is here, the sanctions imposed and what his/her expectations are regarding therapy.**

- **Informed Consent:**
    - Clarify the expectations and "terms" of treatment.
    - Inform the client that this is a treatment program designed to provide students with treatment options when found responsible by their schools for sexual misconduct.
    - Discuss the standard limits of confidentiality (i.e., mandated reporting requirements as dictated by state law).
    - Treatment is confidential, but the therapist may inform the school about compliance and treatment completion. No other details, or information will be shared with the school. (Note: A release should be obtained from the student to allow the therapist simply to communicate yes or no about treatment compliance and treatment completion to the college/university.)
    - If the student is reluctant to consent, the therapist might explore the student's concerns. Under no circumstances, however, should the student be pressured to consent. If the student chooses not to sign the consent form, the therapist must explain that she / he will have to inform the school and that doing so may result in the school revisiting the conditions of returning to campus.
    - The therapist should emphasize that no information will be released without prior review with the student.

- **Orient the student to the therapy program:**
    - Expectations – clinician, client, and institution.
        - Therapist's policies about cancellations, tardiness, no shows and fees may be briefly discussed and a treatment contract reviewed.
    - Expectations of the student and goals of therapy: **Why are you here?**
      * *Reminder about the standard limits of confidentiality*

- **Goals: Complete Risk and Needs Inventory:**
    - Complete the Risk Needs Inventory
    - Add other tests, scales or measures, if indicated.

→ Possible Activities: Initial Assessment and Engagement

- Provide preliminary information and ensure informed consent.
- After preliminary information is covered and an informed consent form is signed, transition to the Clinical Interview (Appendix E).
- The focus should be on gathering relevant initial assessment information and establishing the therapeutic relationship.
- If the client consents to treatment but is not forthcoming or providing terse answers, the clinician may ask the client about this. It may be necessary to shift away from an interview style and take more time establishing rapport, or exploring the client's reluctance/ambivalence until the client is comfortable and more engaged.
- Use of scaled/ruler questions to access motivation and confidence about engaging in treatment. See example below.
    - On a scale from 1-10, with 1 being none to 10 being very much so, how confident do you feel you can make necessary changes (e.g., perhaps avoiding negative peer influences, partying lifestyles)?

The therapist might suggest that the client identify any areas or issues that he/she is reluctant to talk about or uncomfortable talking about, but may be willing to discuss later.

It may be useful to reinforce that honesty is vital and that the therapist's job is to help not judge the client.

→ Possible Out-of-Session Assignments (OSA):

- Ask the client to take time during the week to reflect on the first session and jot down any thoughts, questions, or concerns that came to mind.
- Ask the client to create a pro/con list regarding participating in therapy.
- If the clinician did not address strengths and weaknesses, ask the client to create such a list.

→ Check Out (5-10 min):

- **Ask client:**
    - Any additional questions about treatment, policies, or anything else?
    - Any concerns?
    - Anything else that we didn't address?
- **Introduce next week's session.**
- **Complete initial assessment.**
- **Develop a treatment plan.**

→ Supplies/Handouts:

- **HIPAA guidelines.**
- **Therapist's contact information and policies .**
- **Informed consent agreement (two copies) .**
- **Signed Release form to inform college or school about compliance and treatment completion ONLY.**

SESSION 2: **CONTINUED INTAKE ASSESSMENT**

Session Goals

- Orient the client to therapy.
- Describe and set the framework for treatment.
- Develop rapport and engage client.
- Begin the Initial Assessment.

→ Check In (5-10 min):

- Briefly check in about client's week.
- Briefly ask about thoughts, questions, and concerns regarding the last session.

→ Suggested Session Content:

- Complete intake assessment.
- Assess and encourage motivation to examine behavior related to misconduct.

→ Possible Activities:

- Complete the RNI with the client or following the interview.
- Assess motivation to engage in therapy and address misconduct.

→ Possible Out-of-Session Assignment:

- Have the client mull over the events – all of the events – that led to being assigned to therapy and write down all initial reflections of what happened and what led up to it. This assignment is intended to be reflective; it is not an "academic" essay. It need not be long or written as a formal narrative. It could even be bullets if that suits the client. It must be done privately, with no outside input.

- Any additional questions about treatment, policies, or anything else?

→ Check Out (5-10 min):

- Query client about any questions, concerns, or omitted topics.

- Introduce next week's topic.
    - Including review of assessment and how it may inform the treatment plan.
    - Next session - sexual behavior and consent.

MODULE 2

Sexual Behavior & Sexual Misconduct

Sexual Behavior & Sexual Misconduct

SESSION 1: **SEXUAL BEHAVIOR & SEXUAL MISCONDUCT: HOW THEY DIFFER**

Session Goals

- Finalize the Treatment Plan.
- Develop an understanding of the difference between healthy and respectful sexual behavior compared with sexual assault and other forms of sexual misconduct.

Session Objectives

- Review assessment findings and agree upon the Treatment Plan.
- Without embarrassing and/or shaming, this session is intended to help the client understand the differences between healthy, mutual, and respectful sexual behavior, and offensive/abusive sexual behavior.
- Build comfort in talking about sex appropriately. Develop a prosocial, common language.

Session Objectives... continued

- Clarify the difference between sexual thoughts and fantasies, feelings, and behaviors.
- Distinguish healthy sexual behavior from offensive, abusive, and illegal sexual behavior.
- Develop an understanding of the range of healthy sexual behavior.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Discuss assessment findings, including the RNI, and proposed treatment plan. Develop consensus regarding the treatment plan. Client and clinician sign the plan.
- Review the range of sexual behaviors, including masturbation and fondling as well as oral, vaginal, and anal intercourse. Also include noncontact sexual behaviors such as flirtatious sexualized comments and innuendos, and consensual sexting. Ask for, or provide if necessary, anatomically correct terms and non-slang jargon for sexual acts. Discuss why these will be expected in treatment (e.g., clear and respectful communication).
- Clarify that the stereotype of sexual misconduct involving violent and stranger rape is the exception. Most sexual assaults and sexual misconduct are perpetrated by people known to the person who is assaulted.

- Review the range of sexually assaultive and offensive behaviors, such as hands-off sexual misconduct including sexual harassment, stalking, unwanted sexual gestures, sexual graffiti, nonconsensual or underage sexting or Internet posting, cyber-sexual bullying, voyeurism, underage pornography, and exhibitionism. Also review hands-on offending, such as frottage, nonconsenting sexual touching or penetration due to incapacitation, power differential, pressure or force, and aggression.

- Note how healthy, mutual, and respectful sexual behaviors, between consenting individuals, regardless of their sexual orientation or identity, differ from offensive, abusive sexual behavior.

- Discuss why sex is a powerful drive (e.g., feels good, may show affection and love, is fun; and may serve other functions as well, such as a tension release, relieving immediate feelings of loneliness, may increase feelings of being strong, powerful, competent, and boost self-esteem).

- Differentiate healthy sexual behavior from assaultive and offensive sexual behavior and introduce the concept of consent (e.g., able to knowingly and freely agree and disagree).

- Assess motivation to engage in therapy and address misconduct.

→ Possible Activities:

- Brainstorming activities may be done through discussion, the clinician may serve as a scribe, or both the clinician and individual may jot down ideas and examples and then compare and discuss listings.
    - Cooperation may be increased by suggesting, "Let's see how many ideas we can come up with in two minutes," prompt or take turns as needed.
    - Also, depending on the topic, a two-column chart may be useful to develop comparisons, (e.g., differences between healthy and safe sex verse offensive or abusive sexual misconduct).

- Assist the client in:
    - Discussing terms for sexual body parts and the range of possible sexual behaviors to develop a common language. Encourage client to use any word that comes to mind in this exercise, even "street" or derogatory terms. Later, the terms used can be discussed and the differences between socially acceptable language and street terms can be noted. Ask for, or provide appropriate terminology, if necessary, and discuss why socially acceptable terms will be expected in treatment

(e.g., clear, respectful communication, decrease arousal).

- Discussing why sex is a powerful drive (note content above).
- Brainstorming and discussing the differences between healthy and safe sex compared with assaultive and offensive sexual behavior (again as noted above).

- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- **Instruct the client to look for examples of healthy and abusive sexual behavior in everyday life, including descriptive reports in the news and other media sources; either cut out, print examples, or make a written list to briefly discuss next week.**

- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- **Ask the client to answer one or more of the following questions:**
  - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
  - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?

- **Introduce next week's topic.**
  - Next time we will talk more about how we can ensure our relationships are healthy and not abusive.

→ Supplies/Handouts:

- RNI
- Treatment Plan
- Fictitious case examples or examples generated in session
- Computer, paper and writing implement, or white board and markers for written activities
- Resource flash drive

SESSION 2: **RELATIONSHIPS & CONSENT: WHAT IS CONSENT**

Session Goals

- Understand the importance of relationships in our lives and the necessity and positive value of consensual, respectful, and trusting relationships that ensure safety and mutual wellbeing.

Session Objectives

- Understand how relationships are important in our lives and what it is that we value in our relationships.
- Develop increased understanding of the difference between coercion/manipulation/exploitation and consent.
- Understand the importance of consent/agreement in our sexual relationships.
- Introduce guidelines for safe, healthy, mutual, and respectful sexual relationships.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, and thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Review various types of relationships (e.g., parents and adult caregivers, relatives, teachers, friends, acquaintances, romantic interests and dates, committed partners, "Friends with Benefits," "Best Friends for Sex," and "Hook-ups").

- Discuss what healthy and positive relationships are, and how they differ from those that are not healthy or positive.

- Review why relationships are important; how do they positively or negatively impact our lives?

- Discuss the difference between coercion and consent, (e.g., bullying, pressuring, and cajoling are not acceptable pathways to consent in any situation whereas mutually agreed upon (and legal) activities may indicate consent, and in essence is similar to agreeing to a contract, consenting to date, or ultimately to marry).

- Consent and sexual behavior
    - Sexual misconduct is not just about physical force and violence.
        - Age matters (legal age for consent varies by state and federal law)
        - Ability to consent (must not impaired in any way)
        - Not pressured at all (no coaxing, persuading, cajoling, guilt tripping, or threatening).

→ Possible Activities:

- Brainstorm with the client various types of relationships as described above, and discuss what was or is important about these relationships. Encourage client to select several relationships to focus on and discuss what was or is helpful and valued about them, as well as what was or is disliked, and also consider whether these relationships have been healthy and positive; unhealthy, negative, hurtful or harmful; or none of the above.

- Build on the discussion about the positive and negative aspects of the client's relationships to begin brainstorming the difference between coercion and consent.
    - First help the client identify nonsexual examples, such as school bullies who pick on other students, contrasted with students who join anti-bullying campaigns.

- Next discuss examples of consenting compared with coercive sexual behavior. Draw on the distinctions made in the last session regarding healthy and mutually agreed upon sex, compared with abusive and offensive sexual behavior (An example of sexual misconduct that may seem innocuous to some is when someone draws sexual anatomy on a classroom white board. Such behavior may be emotionally hurtful to some individuals because it may trigger post-traumatic stress for someone who has been sexually abused. It also is coercive in that people entering the room did not consent to view this picture, an image that may be experienced as upsetting and offensive).

- **Introduce the acronym CERTS: Consent, Equality, Respect, Trust, and Safety[1], as a guiding principle for legal and healthy relationships and sexual behavior. Provide brief definitions of these terms (http://healthysex.com/healthy-sexuality/part-one-understanding/the-certs-model-for-healthy-sex/). An electronic version is on the flash drive.**

- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- **Instruct the client, for next week, to watch a couple of clinician recommended movies, videos, or television shows that are pertinent to the issue of consent and write down his or her views and reactions for discussion next week. The media viewed may include examples in Appendix F, as well as stories involving characters who are considering or beginning to become sexually involved. Ask the client to write down how the characters apply or don't apply CERTS (Consent, Equality, Respect, Trust, and Safety) in their relationships.**

- **Encourage the client to think about his or her past and current relationships and consider how CERTS (Consent, Equality, Respect, Trust, and Safety) concepts have been applied or ignored in the past and how they may be useful in the future.**

- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

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1 The CERTS model was developed by Wendy Maltz, LCSW, DST or www.HealthySex.com and is used in this program with her permission.

→ Check Out (5-10 min):

- **Ask the client to answer one or more of the following questions:**
    - What were some things you liked about today's session? What didn't you like?
    - What is something new that you learned today or that stood out? How may this be helpful to you in your life?
    - Is there anything else that we didn't get to that you think would have been helpful?
- **Introduce next week's topic.**
    - Next time, we will talk more about sexual behavior and the law and how to stay on the safe side.

→ Supplies/Handouts:

- Handout on CERTS
- CERTS cards

SESSION 3: **SEX & THE LAW**

Session Goals

- Increase the client's awareness that all types of sexual misconduct are offensive and very serious legal consequences can result.

Session Objectives

- Increase awareness of state and federal laws governing sexual behavior.
- Become aware of potential legal (criminal and civil) consequences for sexual misconduct.
- Become aware of public registration as a "Sex Offender" for some sex crimes.
- Further develop understanding of school policies regarding sexual misconduct.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- **Overview of laws regarding sexual behavior.**
    - Emphasize that ages of consent vary by state (e.g., in some states anyone under the age of 18 is considered unable to consent to sexual behavior). Although sexual contact with an underage college student is not a registerable sex offense in most jurisdictions, the issue becomes more complicated when the Internet is involved because of the federal age of consent and what constitutes pornographic images (See Sexual and the Law Power Point).
    - Emphasize that state laws vary and that the client is responsible for being familiar with local laws.
- **Provide overview of college rules and policies regarding sexual misconduct.**
- **Review possible consequences of sexual misconduct.**
    - Criminal justice system (state and federal sentencing, registration and public notification laws, and civil commitment).
        - Adult charges make the news.
        - Arrests of college students for sexual abuse make the headlines.
    - Civil suits
        - May make the news.
    - School practices
        - Note increased attention is likely to lead to increased negative consequences for sexual misconduct.
    - Criminal and civil statues of limitations vary.
        - Bill Cosby in the news.

→ Possible Activities:

- **Sex and the Law PowerPoint presentation of content and stimulus for discussion.**
- **Provide Power Point as handout.**
- **Discuss possible consequences of sexual misconduct (in addition to current consequences; arrest, trial, prison, registration, and so forth) and the impact of these consequences for**

one's self and others.

- Imagine yourself – your face on front page of the school newspaper; imagine you/your story/your face in your local hometown newspaper. How would this impact your family? How would your friends react? How would you feel? How might this affect your future?

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Ask the client to become familiar with local laws governing sexual behavior by reviewing and summarizing state laws regarding sexual behavior.
    - Key points may include, for example, laws regarding age of consent and other illegal situations when age is not an issue, such as when there is a power differential (incapacitation, coach, or tutor relationship, etc.) as well as coercion.
    - Also, ask the client to review the criminal penalties associated with such offenses, including residency restrictions, sex offender registration, and public Internet or door to door notification (this assignment may be expanded in future sessions to include other states or federal laws that may be relevant for the client).

- Ask the client to review school policies regarding sexual misconduct and summarize their understanding of this information.

- Instruct client to review examples of people receiving consequences for sexual misconduct (e.g., news stories or sex offender registries).

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.

→ Check out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some useful ideas presented during today's session?
    - Was there something new that you learned today or that stood out? How may this be helpful to you in

your life?

- Is there anything else that we didn't get to that you think would have been helpful?

- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Sex and the Law PowerPoint presentation overview of general sexual behavior laws, Title IX, and school rules and policies.**

- **Sex and the Law Power Point handout.**

- **Fictitious case examples.**

- **Blog/Article handouts (see appendix F): Son, It's Okay if You Don't Get Laid Tonight, 7 things that have nothing to do with rape perfectly illustrate the concept of consent link.**

- **Computer, paper and writing implement, or white board and markers for written activities.**

MODULE 3

Focus on Socialization & Sexualization in Society

Focus on Socialization & Sexualization in Society

SESSION 1: **GENDER SOCIALIZATION & SEX**

Session Goals

- Facilitate understanding of where our attitudes about relationships and sex come from (e.g., Parents, Peers, Media/Advertising) and how our socialization shapes our perceptions of masculinity and femininity, ideas about gender roles/stereotypes, and how these perceptions impact sexual relationships and behaviors.

Session Objectives

- Introduce the concept of gender roles and gender stereotypes.
- Discuss how family, friends, and others influence our understanding of gender roles and stereotypes.
- Explore how the media (audio, video, social media) portrays images and ideals of masculinity and femininity and promotes stereotypes of how men and women 'should' act in sexual relationships and situations.
- Examine how these gender images and stereotypes influence our ideas and beliefs about heterosexual, lesbian, gay, bisexual, and transgender individuals.

Principal Contributors: Righthand, Lopez, Lamade & Prentky

Session Objectives... continued

- Discuss how these socialization messages may influence, promote, or hinder our relationships and ability to see people as people.
- Recognize how these influences may affect sexual behavior and may impact understanding the difference between consenting and abusive sexual behavior.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, and thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- **Discuss what it means to be a "real man" or "real woman." Explore stereotypes and reality.**
- **Review socialization messages throughout childhood, adolescence, and emerging adulthood. Where do these messages come from (family, peers, media)? What messages stand out about gender roles and stereotypes? What about alternative gender identity and sexual orientation?**
    - Explore positive and negative media messages related to relationships and sexual behavior.

→ Possible Activities:

- **Brainstorm with the client gender socialization messages that the client received in childhood and adolescence about how to be a "real man" and "real woman." Include nonsexual and sexual examples of these messages. For example, have client list as many messages as she/he can think of with the sentence stem: "Women should…;" "Men should…" and "Women shouldn't…" and "Men shouldn't…"**
    - Evaluate where these messages came from and their influence; positive or negative; minimal or significant.
    - Debate how accurate these "shoulds" and "should nots" are.
    - Discuss what these messages tell us about how men and women should act during potential sexual encounters ("hookups", "friends with benefits", dating, committed relationships) and at parties? Consider how gender stereotypical messages may influence the CERTS concepts discussed in Module 2 (Consent-Equality-Respect-Trust-Safety).
    - Also discuss how gender socialization experiences, such as how messages in the media, peers, etc., affect social and sexual norms on college campuses?
        - Is there pressure to be/act in ways that are in-line with gender stereotypes, but that might lead to negative attitudes or behaviors?
- **Ask/discuss how gender socialization has affected the client's attitudes, beliefs, behavior, and life.**
- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- **For next week, ask the client to pay attention to examples of socialization messages that portray gender roles and stereotypes; for example, from friends, the media, etc.**
- **Or, suggest the client view and write down comments about how gender roles and stereotypes are portrayed in the media for discussion next week (video options should be reviewed and selected by clinician beforehand: See Appendix F). Ask the client to consider and write down what media messages say about how "real men" and "real women" should be; how the media portrays flirting and sexual behavior, and suggests how we should behave in sexual encounters. What messages about consent are suggested or provided? Include examples of inappropriate behaviors as well as respectful ones.**

- Or, encourage the client to critique and bring in a variety of messages; they could be songs, music videos, ads, peer or family comments, etc. that promote positive, respectful, and equal relationships between genders, as well as those that negatively stereotype and may encourage non-consenting, unequal, disrespectful, and unsafe behavior.

- Assign relevant multimedia resources, exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer the following questions:
    - What I found useful about today's meeting was _____.
    - What I'd like to know more about is _____.
    - How has our time today together been helpful? What could make it more useful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 2: **SEXUAL KNOWLEDGE, RISKY SEX AND SEXUAL MISCONDUCT**

Session Goals

- Help client recognize that risky sexual behavior and sexual misconduct are serious problems that require correction.

Session Objectives

- Facilitate client's awareness of how the client has learned about sex, sexual relationships, and consent.
- Help client identify the benefits and risks involved when engaging in sex with new acquaintances and uncommitted hookups.
- Introduce risky thoughts, feelings, behaviors, situations, and other factors that may promote sexual abuse (these areas will be covered in more depth in later sessions).
- Help client identify the problem of sexual abuse on/off college campuses.
- Develop understanding of situations, climates, and cultures that may encourage sexual misconduct and abuse (e.g. rape cultures).
- Reinforce difference between sexual abuse and consenting sexual activities.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Review how and what the client learned about sex (from parents, friends, the media, pornography) re: anatomy, pregnancy, STI's, sexuality, sexual intimacy and relations.
- Consider how helpful and accurate this information has been as well as how it has or has not been helpful in preparing the client for intimate and sexual relationships (e.g., perceived stereotypes about gender roles and expectations).
- Review distinction between healthy, mutual, and respectful sexual behaviors between consenting individuals and sexual misconduct: reintroduce CERTS.
- Help the client recognize what some may consider normative sexual behaviors, such as casual sex (e.g., sex with no commitment, "hook-ups," and "friends with benefits"), can be risky and may contribute to sexual misconduct.

→ Possible Activities:

- Discuss how the client has learned about sex, how useful and accurate it has been, and how it has influenced his/her behavior.
- Briefly review the distinction between healthy, mutual, and respectful sexual behaviors between consenting individuals and sexual misconduct and reintroduce CERTS.
- Present information about Campus Sexual Misconduct:
    - Provide a Campus Sexual Misconduct Fact Sheet.

- Discuss the problem of sexual abuse on campus, prevalence, impact, and response (may use Fact Sheet to keep factual focus).
- Describe what is known about students who have engaged in sexual misconduct and those who have repeatedly engaged in such behavior[2].
    - In confidential studies, about one quarter, or slightly more college men report having engaged in contact (hands-on) sexual misconduct since the age of 14; fewer report acts of rape (7-11%). Rates of women perpetration are notable, but typically much lower than those of men. Similar to men, women use verbal coercion, incapacitation, threats, and force.[3]
    - Approximately 15-20% of college women report experiencing rape or attempted rape during college and over 50% describe some type of unwanted sexual touching (higher rates may include abusive experiences in high school). In addition, high rates of victimization are found among women who are among sexual and/or ethnic minorities and those with disabilities. Men also are victims of sexual misconduct, although not as often as women.[4]
    - Research studies focusing on men shows that those who engage in unwanted sexual contact repeatedly typically have the highest number of previous sexual experiences, most often drink in sexual situations, have extreme hostility toward women, and have high rates of adolescent delinquency[5]. There is limited research regarding women who engage in sexual misconduct.[6]
    - Men who engage in sexual misconduct report greater peer approval of forced sex than do non-abusive peers. Being part of a social group that condones treating women as sexual objects can provide encouragement and justification for engaging in sexual misconduct.[7]

- **Watch or listen to a video clip or song that normalizes casual and uncommitted sex, partying, and risky sexual behavior or sexual misconduct and provide a critique (See resource listing).**
- **Discuss how one ensures that sexual interests, advances, behavior is mutual and consenting.**
- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

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2 For a brief review see: White, Koss, Abbey, Thompson, Cook, & Swartout, (2015).
3 Palmer, McMahon, Rounsaville, & Ball, (2009).
4 White, Koss, Abbey, Cook, Ullman, & Thompson (2015).
5 Abbey & McAuslan (2004), White, Koss, Abbey, Thompson, Cook, & Swartout, (2015)
6 See Program Participants Section for a brief review pertaining to women who engage in sexual misconduct.
7 Abbey & McAuslan (2004)

→ Possible Out-of-Session Assignments:

- Ask the client to research information on campus sexual misconduct during the course of the next week; evaluate the nature and extent of this problem and list some opinions about what should be done about it.

- Have the client compile a list of sexually derogatory and demeaning remarks made by public figures and others to discuss next week.

- Assign relevant multimedia resources, exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check out (5-10 min):

- Provide two comments about today's session. Ask the client to answer one or more of the following questions:
    - How may this information be helpful in your life?
    - Is there anything else that you would like to know more about?

- Introduce the next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 3: **PEER INFLUENCES**

Session Goals

- Recognize the value of positive peer relationships, identify how harmful and insidious negative peer influences can be, and begin to develop strategies to counter them.

Session Objectives

- Assist the client in evaluating peer associations and influences.
- Help the client recognize that people may present themselves in ways that may or may not be true.
- Help the client identify negative peer influences, and how he/she may have allowed such influences to impact his/her behavior.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Discuss positive and negative peer pressures (e.g., someone who may be there for you when you need someone versus someone who encourages binge or competitive drinking, as well as someone who pressures or coerces you to engage in behavior against your better judgment).

- Examine the accuracy of how peers may present themselves and how such presentations may lead to erroneous beliefs about other's behaviors (e.g., research shows that students' perceptions regarding how sexually permissive/active others are may not be accurate).

- Introduce research findings that young adults often overestimate others' involvement with risky and even negative behaviors while underestimating adherence to positive, prosocial behavior. Be sure to note that individuals who believe their peers support sexually coercive behavior are more sexually aggressive themselves and are less likely to intervene when they observe sexual misconduct.

- Review negative group psychological influences that may contribute to a "rape culture" (i.e., the shared belief that rape is prevalent and sexual violence is normal, acceptable, and excusable). In other words, peers validate, condone, or approve of coercive sex. Further, some peer groups encourage sexual competition, such as when sexual conquests are seen as a way for a male to prove he is a "real man". Sometimes, some individuals consider sexual misconduct appropriate payback for perceived slights or wrongdoing (e.g., turning down a request for a date).

- Perhaps discuss Diffusion of Responsibility research[8] (i.e., people are less likely to feel a sense of responsibility and take action when they are part of a group) and the importance of having the courage to act alone.

- Perhaps discuss the literature on Groupthink[9] and Herding; why we go along with the herd, who doesn't; who are "Black Sheep"; the courage to choose to be a Black Sheep. See Groupthink Power Point in Appendix F.

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8 Darley & Latané (1968).
9 Janis (1982).

→ Possible Activities:

- **Explore personal peer influences:**
  - List peers who have been positive influences in your life, and discuss how.
  - List peers who have been negative influences in your life, and discuss how (Initials or first names are fine).
  - List examples of when you have been a positive as well as a negative influence in peers' lives, and discuss how. Include your retrospective reflections. What would you say to them now if you could speak openly and honestly?
  - How did they or you influence each other regarding sexual misconduct?

- **Review concepts such as Groupthink, Herding, and Diffusion of Responsibility (Note: a PowerPoint presentation on Herding is available in Appendix F).**

- **Discuss factors that may contribute to the shared belief that rape is prevalent and sexual violence is normal, acceptable, and excusable. Present information to the contrary.**

- **Ask the client about his/her awareness of individuals or groups that support and encourage sexual misconduct (assure the client that you are not looking for names or to identify people, but to help him/her critically evaluate their behavior). Ask the client what attitudes and beliefs justify his/her behavior, what she/he thinks supports such positions, and what information is available to counter these attitudes and beliefs.**

- **Ask the client to consider the information previously presented regarding the tendency for students to overestimate the frequency of risky and negative behaviors among their peers while underestimating the occurrence of positive, prosocial behaviors. Ask the client how such factors may have influenced the client.**

- **If the client's sexual misconduct clearly was peer influenced or was part of group sexual misconduct, have client identify factors that may have contributed to his/her willingness to participate (e.g., acceptance, approval, peer validation and support, comradery, intimacy needs) as well as the perceived negative consequences of not participating (e.g., rejection, embarrassment, loss of face, etc.), and help the client brainstorm ways to avoid such situations (e.g., saying no to participating or, if being direct currently is too difficult, asserting an obligation that requires the client to be elsewhere) and begin to address the emotions related to the circumstances.**

- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- Ask client to review the PowerPoint presentation on Herding in Appendix F and use it to identify times Groupthink influenced him/her as well as times when she/he stood out like the Black Sheep in the herd, or would like to do so.

- Encourage client to view a movie or other media that depicts the negative peer influences that may lead to sexual misconduct (e.g., select several for client to choose from; see Appendix F for ideas). Ask the client to use information learned in previous sessions to identify stereotypic beliefs and behaviors that may increase risky sexual behaviors and promote sexual misconduct. Request that the client write down these ideas for a brief discussion next week and his/her reactions to the film.

- Additionally, ask the client to review and bring in information next week that demonstrates a shared societal value in opposition to those professed in groups supportive of sexual misconduct (e.g., sexual entitlement, no need to ensure consent, the belief that coercive sex is acceptable in some circumstances, etc.). An example may be former Vice President Biden's presentation of Lady Gaga and the group of survivors at the 2015 Academy Awards show. Ask the client to provide a written critique of this information.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you found useful in today's session? What wasn't useful?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

MODULE 4

Understanding & Resolving Risks for Sexual Abuse

Understanding & Resolving Risks for Sexual Abuse

SESSION 1: **RISKY ATTITUDES**

In this module, clients increasingly begin to identify their own risky attitudes, feelings, and behaviors as well as situations that have contributed to their sexual misconduct and develop strategies to counter them.

Session Goals

- Using information gained in earlier sessions, this session is designed to help the client explore his/her erroneous and problematic attitudes and beliefs that may have contributed to sexual misconduct and ways to correct them.

Session Objectives

- Build attitudes and beliefs intolerant of sexual misconduct.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Identify current or previous personally held attitudes and beliefs that have been, or are supportive of sexual misconduct (e.g., approval of impersonal sex, "partying" and "hooking up", erroneous sexual expectancies, and sexual entitlement). Also explore attitudes supporting gender inequality, distorted beliefs about women, and homophobia. Be sure to identify positive and healthy attitudes and beliefs, as well as those that support respectful relationships.
- Discuss commonly held erroneous beliefs about how sexually permissive/active other students are.
- Discuss coercive and aggressive sexual thinking fantasies and/or antisocial attitudes, peers, and behavior, if assessment findings suggest these may be present.

→ Possible Activities:

- Present the client with myths and facts about sexual misconduct on campuses. Have the client rate them as true/false; correct errors and discuss.
- Have the client list, perhaps on a white board, the risks and benefits of sexual misconduct. If hesitant, assist in brainstorming the list, and then help the client critically evaluate the list.
- Building on previous sessions, have the client name attitudes and beliefs that some people have that support sexual misconduct while clinician scribes. Next, discuss which of these attitudes and beliefs the client thinks are valid. Ask the client whether any of these

beliefs may have negatively influenced the client and contributed to the client's sexual misconduct.

- Next, ask the client to brainstorm evidence in opposition to these attitudes and beliefs as the clinician scribes. If the client has difficulty identifying prosocial attitudes, beliefs, and behavior in opposition to those that support sexual misconduct, provide information and evidence demonstrating that most people do not have such attitudes and beliefs.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Consider asking the client to critically review sexual behavior messages in the media. Instruct him/her to consider and rate their likely accuracy and how these messages may have negatively or positively influenced the client's attitudes and beliefs about sexual behavior. Request that the client write down the critique for discussion next week.

- Or, request that the client research the prevalence of attitudes and beliefs that support sexual misconduct. This prosocial information will be reinforced in future sessions.

- Consider asking the client to jot down reminders of times she/he did not act on attitudes supportive of sexual misconduct in spite of opportunities to do so. Have the client note why the decision not to act in such a manner was selected.

- Or, assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check out (5-10 min):

- **Ask the client to answer one or more of the following questions:**
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - Is there anything else that we didn't get to that you think would have been helpful?
- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

SESSION 2: **RISKY FEELINGS**

Session Goals

- Help the client recognize emotions and feelings that may have or could contribute to sexual misconduct and consider corrective strategies.

Session Objectives

- Identify positive, risky, and negative feelings associated with sexual behavior.
- Help the client explore the role of emotions in relation to his/her sexual behavior and possible risky or negative emotional states.
- Introduce emotion regulation strategies to help manage feelings and behaviors in healthy ways.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Review ranges of human emotions (e.g., happy, sad, angry, glad, jealous, loving, anxious, peaceful). Discuss how the client identifies these feelings in him/herself (e.g., physiologically, affectively, and cognitively) as well as in others (e.g., voice tone, body language).

- Review positive and risky feelings associated with sex (e.g., sexual arousal, love, enjoyment, a personal or emotional connection to the other person or partner, etc., contrasted with sexual entitlement, jealousy, anger, hostility; a desire for power, control, or revenge; perhaps by humiliating the victim; or to assuage feelings of loneliness, sadness, and loss).

- Discuss the use of sex to excessively regulate emotions or intimacy needs or other emotions for self-soothing (such as indiscriminate sex, excessive masturbation, or excessively frequent use of pornography), and introduce better coping strategies.

- Discuss and practice emotion regulation strategies.

→ Possible Activities:

- Discuss the range of positive, risky, and negative feelings associated with sex and ensure that the client and clinician have a common language that describes these mood states.

- Encourage the client to identify the range of feelings that the client personally experiences in association with sex, recognizing that they may differ depending on circumstances and types of relationships. If client is reticent to verbalize the range of feelings, suggest writing them down and share tones that client feels comfortable sharing.

- Encourage the client to identify feelings that feel good and are positive, those that do not feel good, as well as those that may be risky and negative and may have contributed to poor sexual choices or misconduct in the past.

- Introduce emotion regulation strategies (e.g., focused breathing): instruct, model, and practice.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Encourage client to practice identifying various emotional states and record them, perhaps keep an emotion log for the week.

- Ask the client to practice using emotion regulation strategies several times a day, whether or not experiencing negative mood states, and log them for discussion next week. Emphasize that the strategies will not work in the moment if they are not practiced and become a reliable or automatic coping strategy.

- Or, assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 3: **RISKY BEHAVIORS**

Session Goals

- Help the client recognize risky behaviors that she/he engaged in that may have been or were related to sexual misconduct and could be risky in the future; begin to develop corrective strategies.

Session Objectives

- Help the client identify risky behaviors related to sexual misconduct.
- Consider various strategies that may help the client manage such behaviors effectively.
- Begin developing effective intervention skills.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- **Consider potentially risky and negative behaviors (e.g., regular use of sexualized language, frequent pornography/violent pornography use, substance abuse (which will be discussed in more depth in another session), partying, causal sex, and general rule breaking and antisocial behavior).**

→ Possible Activities:

- **Help the client identify risky and negative behaviors the client has engaged in that may have been, were, or could be related to sexual misconduct and evaluate the benefits, risks and costs of these behaviors. To break the ice, maybe suggest discussing nonsexual rules or law-breaking behaviors first (e.g., partying with under-aged students) and then transition to how attitudes and beliefs that supported those and then explore how this behavior may be related to engaging in sexual misconduct (e.g., "When I drink, my judgment may fail me; I could get involved with an underage student").**

- **Discuss information on casual sex (e.g., "friends with benefits", "hooking up")[10]**
    - Casual sex includes anything from kissing and sexual touches to intercourse with people just met, acquaintances, or friends, but with no romantic relationship attachments currently or intended.
    - Increasingly common among adolescents and young adults in North America as traditional patterns of courting and dating have shifted over decades.
    - Music, television and movies depict and may promote casual sex and are strong social influences.
    - Sometimes uncommitted sex is "unintentional," likely due to substance use; in fact, most hook-ups follow alcohol/drug use with an average of 3.3 drinks reported in one study; increased substance abuse has been associated with a greater likelihood of penetrative acts.
    - Best predictor of hooking up is a history of hooking up; one study found those who had engaged in uncommitted sexual penetration were 600% more likely to repeat this behavior. Other associated factors include media consumption as well as personality and biological traits.
    - People often overestimate another person's comfort with uncommitted sex. Men most frequently overestimate women's comfort with various sexual behaviors. Women may feel pressured to go along.
    - One study of first-time hookups found that only 31% of men and 10% of women reached orgasm, whereas 85% of men and 68% of women who engaged in sexual activity in an established relationship did.

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10 See Garcia, Reiber, Massey, & Merriwether (2012) for a detailed literature review covering these points.

- Reported reactions to uncommitted sex are often positive and include enjoyment of spontaneity, excitement, expectation, exploration, and feeling desired and wanted, good and satisfied.
- Other feelings, particularly subsequent to the encounter may include second guessing, mixed emotions, embarrassment, unexpected stirring of romantic feelings, regrets, disappointment, disillusionment, loss of respect, sadness, and loss when platonic relationships fizzle, or difficulties with a steady partner ensue.
- Regrets were most common when hookups occurred with someone known less than 24 hours, as well as when it was a one-time occurrence.
- Physical risks include STIs and pregnancy. However, many appear unconcerned about such outcomes; for example, many do not use condoms, especially during oral sex.
- Physical injury also may occur when hookups become aggressive and violent.
- Not all sexual behaviors that occur during a hookup are consenting (i.e., the hookup involved a sexual act they did not want to have or they were unable to consent). Co-occurring substance use is common in such situations.

- **If relevant, brainstorm with the client the benefits, risks, and costs of casual sex.**

- **Encourage the client to consider the benefits and risks of partying and the hook up culture on college campuses.**
  - Consider: Is it possible to use CERTS concepts during hook ups? How? Why or why not? (Caught in the moment, role of alcohol/drugs, loud music, etc.).

- **Introduce problem solving skills and how they can be used to create and ensure consent by doing the following. One approach is described below and is called "ICED."**

  1. **I**dentify sexual arousal (or other risk indicators, e.g., partying) and the desire to act;
  2. **C**hill and think it through – is this a good idea or the right time or place? Might this person be interested? If so, what should I say and do? If not, how do I manage the rejection, my feelings and behavior?
  3. **E**valuate options and decide what to do;
  4. **D**o what I have thought through and evaluate my choice.

- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- Ask client to practice problem solving skills in multiple settings by using strategies such as the "ICED" technique described above.

- Encourage the client to continue practicing (and logging) emotion regulation skills, at least once a day.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 4: **RISKY SITUATIONS**

Session Goals

- This session provides an opportunity to build on earlier sessions by exploring how risky thoughts, feelings, and behaviors can come together in risky situations and increase the likelihood of sexual misconduct and identify what can be done to prevent it.

Session Objectives

- Help the client build on what she/he has learned in treatment thus far, and identify situations that may have or could increase his/her risk of sexual misconduct (e.g., parties, negative peer groups, dysfunctional intimate relationships and so forth).
- Assist the client in developing increased strategies to avoid and prevent sexual misconduct.
- Help the client develop skills to assertively express their sexual interests, desires, and intimacy needs appropriately with others while actively listening to the other.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- **Review how risky thoughts, feelings, and behaviors can contribute to risky situations. Such situations may include:**
    - Partying and drinking games. Alcohol is present in one-half to two-thirds of college sexual misconducts (alcohol and drug use are covered in more detail in the next session).
    - Problematic relationships (partner violence, male coercion-dependency in females, etc.).
    - Community and societal factors, such as acceptance of sexual violence and "rape cultures," as they may be present in some subgroups.
- **Identify actions and activities that can counter sexual misconduct.**

→ Possible Activities:

- **Have the client identify as many personally risky situations as possible. Discuss the pros and cons of these situations; what was attractive, what was enjoyed, what was risky, harmful, or dangerous. Ask the client to provide details and critically evaluate the setting. Was it all as good as remembered? What wasn't good? If it was as good as remembered, but risky, brainstorm how to manage similar situations safely and successfully.**
- **If appropriate for client, discuss times when she/he was privy to discussions of how to get someone drunk or intoxicated to have sex. Ask the client to use information gained in therapy to critique this discussion and brainstorm possible intervention strategies that she/he could use if faced with such a situation in the future.**
- **Have client brainstorm ways to mutually create and ensure consent when in social situations that may lead to casual sex, but also may result in rejection. Roleplay a few strategies.**
- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F, if indicated.**

→ Possible Out-of-Session Assignments (OSAs):

- Encourage client to write an example of how thoughts, feelings, behaviors, and situations my link together and result in sexual misconduct and ideas how to interrupt this chain.

- If indicated, ask the client to watch a video or read information that depicts a campus rape culture (See resources and provide examples, e.g., It Happened Here). Instruct the client to identify attitudes, beliefs, feelings, and behaviors that promote a rape culture, and the consequences of such a culture.

- Ask the client to critique true accounts from the media. These may include: http://www.huffingtonpost.com/andrea-martinelli/rio-gang-rape-reveals-our-shocking-acceptance-of-violence-against-women_b_10221716.html?utm_hp_ref=world&ir=WorldPost. http://www.buzzfeed.com/jpmoore/23-people-who-think-the-steubenville-rape-victim-is-to-blame

- Have the client write a written parry to rape supporting attitudes and be prepared to debate this anti-sexual misconduct position with the clinician next week.

- Encourage the client to review concepts regarding creating and ensuring consent (e.g., Tea and Consent: https://www.youtube.com/watch?v=oQbei5JGiT8).

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 5: **SUBSTANCE USE & SEXUAL ABUSE**

Session Goals

- The immediate previous sessions have focused on identifying risky thoughts, feelings, behaviors, and situations that could lead to sexual misconduct. The goal of this session is to identify how substance use is related to sexual misconduct and develop skills for avoiding situations and environments where substance abuse is encouraged or facilitated.

Session Objectives

- Help the client to identify situations, environments, and other stimuli personally and on campus that promote binge drinking and use of other substances.
- Explore how alcohol and other substances affect one's ability to recognize and respond to cues from others, control aggression, and make healthy sexual decisions.
- Help the client to differentiate between safe and unsafe alcohol use.
- Develop strategies for risk reduction with substance use: for example, how to identify personal limits, strategies for avoiding or leaving social situations where substances are being used, and identifying supportive peers.

Clinician Note

If the client's substance use is substantial and problematic, consider whether a referral for concurrent substance abuse treatment is indicated and discuss this option with the client. However, if alcohol or substance use is so severe, perhaps the student should be referred to detox and substance abuse treatment, prior to entering STARRSA.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Review of alcohol's impact on physical, emotional, and behavioral health.
- Identify other substances that may be used at parties or in other social situations on college campuses.
    - "Club drugs" such as ecstasy (XTC), GHB, "molly water" that college students may use to enhance party/club/rave experiences.
    - Methamphetamine and other stimulants, such as the prescription medications Adderall and Ritalin, often used by college students to stay awake and study.
    - Prescription opiates, such as Vicodin, Oxycontin ("Oxy"), Lortab, Morphine, and Fentanyl, that some college students use with or without alcohol to relax or sleep.
    - Other "date rape" drugs, such as Rohypnol (roaches, rochas, roofies).
- Identify how substance use can be related to sexual misconduct.

→ Possible Activities:

- **Have the client identify what types of risky situations they have seen or heard about on campus that involve alcohol and/or other substances. What games or chants, if any, are involved with these situations (e.g., beer-pong; chants of "black out or back out")? How much alcohol and what kind(s) of alcohol do college students drink? What happens if someone says they don't want to drink or use other substances at a party or bar?**

- **Brainstorm with the client the ways that alcohol and other substances might impact sexual decision-making and sexual functioning.**
    - Do substances impact ability to become sexually-aroused or to maintain sexual arousal?
    - Do substances reduce social anxiety and facilitate social interactions?
    - How do substances affect the level of sexual pleasure?
    - How does substance use affect ability to get consent?
    - How do substances affect the ability to have safe sex?
    - Potential exercise to accompany this brainstorm conversation: Set a timer for sixty seconds. Have the client attempt to put a condom on a banana with his/her eyes closed, while you are playing loud music or otherwise trying to distract them verbally. This experience is meant to simulate attempting to use a condom without all of their sensory faculties in optimal operation, while being distracted by outside stimuli (e.g., party music and noise). Discuss the experience with the client after the timer has gone off. How would this experience have been different without a timer, with his/her eyes open, and without added distractions?

- **If appropriate for the client, conduct a Functional Analysis of substance use. What are the positives of substance use (i.e., what do he/she "get" from it)? What are the negatives? What are alternatives?**

- **Have the client brainstorm ways in which personal decision-making changes when drinking and/or using other substances. What are the physical changes they experience? Emotional? How does decision-making change after a few drinks?**

- **Have the client think of a specific situation (sexual or non-sexual) when drinking or using substances with others. Have the client identify the physical, emotional, and behavioral effects of alcohol or other substances in this situation. How might it have been different if he/she were not using, or using less?**

- **If appropriate for the client, brainstorm strategies for substance cessation or reduction. On**

a large sheet of paper, have client write out the thoughts, feelings, environments, situations, and peers that encourage, facilitate, or stimulate the client to want to engage in risky substance use behavior. Examples might be social anxiety, parties, stress from coursework, or negative peer groups. Next, for every environment, situation, or peer that encourages the client to use substances, have the client write out two alternative environments, situations, or peers that can assist the client in avoiding or reducing substance use when the client is experiencing distress or confronted with the opportunity to engage with the risky environments, situations, or peers.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- If the client would benefit from substance use reduction and is motivated to do so: ask him/her to research levels of intoxication, and write a paragraph about how the client personally feels at each level of intoxication. What personal warning signs indicate she/he is nearing a level of substance use that is unsafe? Have the client bring this paragraph next week for discussion with the clinician.

- If the client would benefit from substance use cessation and is motivated to do so, ask him/her to make a list of five triggers for substance use. For each trigger, have client list a specific resource, peer support, or alternate activity. Have the client bring this list for discussion next week.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you

think would have been helpful?

- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Paper and writing implement**
- **Condom**
- **Banana**
- **Timer**

MODULE 5

Negative Masculinity

Negative (Hostile) Masculinity

The purpose of this module is to develop an understanding of the differences between healthy and hostile masculinity (i.e., negative masculinity), and its relationship to sexual misconduct. Although "hostile masculinity" is the preferred term in the literature, we suggest using the term "negative" masculinity with the students, so-as-to avoid the almost inevitable repudiation: "I am not hostile!"

Arguably, the most critical clinical issue can be embodied in one simple word: misogyny. What is misogyny? A set of deeply ingrained core beliefs and attitudes about women, sexuality, and relationships that are fundamentally hostile, demeaning, and degrading. These attitudes form the foundation of hostile masculinity in many young clients (as well as adults). As noted, these attitudes and beliefs are often deeply rooted and firmly held. They are egosyntonic. They are firmly held, because they have been – and continue to be – reinforced by a culture that supports such attitudes as normative; if these attitudes are normative, they must, by definition, be healthy – it's what everyone else thinks. These attitudes are directly espoused and indirectly reflected or implied by the marketing and advertising industries, in professional sports, and in movies. This may ultimately be the biggest challenge to overcome.

SESSION 1: **WHAT IS NEGATIVE (HOSTILE) MASCULINITY?**

Primary Goal

We recommend that the wisest approach may be to acknowledge what is obvious and to work with the client to probe and examine what is truly healthy, what is not, and why it is not. Surmounting this obstacle is often a core part of treatment. Treatment will fail, or at least is likely to achieve less than optimal results, if this issue is not carefully and thoughtfully addressed (i.e., in a way that does not alienate or antagonize the client or discredit the clinician). This can only be accomplished by providing a clear blueprint for what healthy masculinity is and why. After which, the umpteen examples of healthy and unhealthy/hostile masculinity showcased in our society can be dissected, and the elements of what is healthy and what is unhealthy can be discussed.

Clinician Note

This is the only module in which we post an advisory about clinician gender. When the clinician is a woman, male clients may become more defensive when discussing thoughts, feelings, and attitudes about who women are to him, about both emotional and physical intimacy, about sexuality in general, about casual hook-ups, about dating and relationships, and about "partnering" with another person (e.g., what is owed to me, what do I owe the other person). In sum, when the clinician is a woman, it may be necessary to directly raise the question of whether discussing these things is made more difficult. When the clinician is a man, vulnerability is less of an issue: "Hey man, you're a guy. You understand." There is a "common language" about sex among "all guys" so communication is easy...If clinician gender appears to be presenting an obstacle and transfer to a male clinician is not feasible, a prosocial, healthy masculine role model and mentor who can assist with these issues may be an option.

The gender/sexual orientation focus of this Module is based on heterosexual males. This Module was not designed for heterosexual females or for lesbian, gay, bisexual, or transgender (LGBTQ) students. Although many of the issues raised in this module are frequently encountered by gay men, lesbian women, and among transgendered students, the clinical issues raised here target heterosexual males. This Module can easily be adapted to the needs of heterosexual females and to LGBTQ students struggling with their positionality in relation to misogyny. We have attempted to address these issues in other modules (e.g., see Module 3: Focus on Socialization & Sexualization in Society).

Session Objectives

- This session is intended to help the client understand what makes up or contributes to our perception of ourselves as masculine or feminine.
- Review where our gender identity comes from.
- Learn what unhealthy masculinity "looks like" and where it comes from and how it influences us?.
- Learn how unhealthy or negative masculinity is associated with abuse in general, such as partner abuse, and sexual misconduct in particular.
- Develop an understanding of the range of thoughts, attitudes, feelings, and behaviors associated with healthy masculinity.

Session Objectives... continued

- Begin to evaluate what personal attitudes, feelings, and behaviors that the client has had or engaged in that are associated with unhealthy masculinity, question them, and identify alternative ways of thinking and behaving.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Discuss what it means to the client to be a "man" and/or what it means to be "masculine." What does it mean to you when you think of yourself as a man or masculine? Follow-up questions may include: Do you see yourself as masculine? What does it mean to you to be masculine? Is "masculine" a matter of degree (somewhat masculine, very masculine, a stud)? Is it about appearance? Is it inherent? Body shape? Athletics?
- Name some famous people that you think are really masculine. What makes them masculine in your mind? Who were your masculine heroes when you were growing up? What made them heroic to you? Were there feminine heroes? What makes them heroes in your mind? For the masculine heroes, was there a difference between being heroic and being masculine? For the masculine and feminine heroes, is there a difference in what makes them heroic?
- Did you ever see the movie Kill Bill, in which Uma Thurman plays the role of an assassin called The Bride and takes out her revenge by slaying dozens of enemy combatants – mostly male? This is typically how men are portrayed in these action thrillers with lots of brutal

killing. What are thoughts about a woman taking on this role? Does she become, in your mind, "macho" or some other version of being feminine?

- How about the more recent very popular movie series The Hunger Games depicting Katniss Everdeen as a very unusual female "hero." Did you see any of those Hunger Game movies? How did you react to Katniss as a character? Does she strike you as a "hero"? If so, what made her a hero in your opinion?

- If the client saw The Hunger Games, you might further explore what made Katniss a very unusual female hero. You might try to explore some of the differences between Katniss and more stereotyped female "heroines": Katniss is attractive but she is not a sex symbol and her sexuality is not what defines her; she fights her own battles and does not rely on men to protect her or rescue her; there is no clinging dependence on men; she is characterized by the kind of internal strength, courage, and fortitude that we typically associate with male heroes.

- The key clinical issue is to begin to melt the artificial divide imposed by rigid conceptions of who ("real") men are and who ("real") women are. The traits the client so prizes in some men are clearly observable in some women and those same traits are only minimally observable or absent in some men. After all, we only have heroic males in fictional roles because that package of traits we so prize and pay homage to are not present in the vast majority of men. By shrinking the rigid dichotomy of who "men" are and who "women" are we begin to overcome the "dis-similarities" that make women "strangers" to men. Although it is long before their time, John Gray's (1992) book *Men are from Mars, Women are from Venus* might be brought up. The title of the book has become a part of pop culture.

- How do attitudes about women, sex, and relationships develop? How much influence did your parent(s) have? Do you see it as related to their gender? How about your guy friends when you were growing up? How about your girl friends? What crowd did you hang with in junior high school? Were they all one gender? How about in high school? What kind of influence do you think your friends had when it came to dating, sex, and views on gender, femininity and women? How strong was your peer culture about the be all and end all of "scoring"? What messages did you get from your parent(s) about these things?

- Do you ever recall feeling like something of a chameleon, going along for the ride, saying things or pretending you were something you weren't just to be accepted by a group of friends?

- Did you ever do something on a lark, just to be "cool"?

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- **These are intended to be Out-of-Session Activities with an assignment to bring into session a "reaction" paper, or some similar documentation of thoughts, and feelings about the video, Ted Talk, Power Point presentations, or attitude scale, etc.**
    - PowerPoint presentation of quotes of politicians about women.
    - Have the client complete a rape myth scale. Discuss with the client "attitudes" from one or more of the many rape myth / cognitive distortion scales and discuss his own myths / attitudes.
    - Have the client complete one of the many scales on stereotypic characteristics of hyper-masculine men and discuss which he identifies with.
    - Have the client watch one of the excellent YouTube videos from athletes and soldiers, such as:
        i. Male athletes against violence: https://www.youtube.com/watch?v=-I7UAtd2h88
        ii. Cadets against violence: www.youtube.com/watch?v=VYzy6gsCqnE
        iii. Jackson Katz video: https://www.youtube.com/watch?v=ElJxUVJ8blw

- **The clinician could intentionally espouse sexist attitudes, even far-fetched sexist attitudes, get the client to disagree, get him to defend his opinion that the clinician's attitudes are "wrong" or don't 'make sense'; get the client to challenge the clinician.**

- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- **Ask the client to answer one or more of the following questions:**
    - What did you think about today's discussion about negative/hostile masculinity?
    - What were some things you found useful in today's session? What wasn't useful?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - Is there anything else that we didn't get to that you think would have been helpful?

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 2: **MOVING FROM THE ABSTRACT TO THE PERSONAL**

Primary Goal

The primary goal of Session 2 is helping the client more fully understand, accept, and ultimately embrace a view of masculinity that is healthier, more humane, and more prosocial.

Clinician Note

Direct, open, and honest discussion is imperative. The client should be assured that there is nothing wrong or immoral about having sex, and, moreover, that women enjoy having sex too. Sex can be a lot of fun and feel good for both people, but only when both people want it, and it is fully consensual. Only then is it fun. Men have to learn to talk about it; women will respect a man for being able to listen to her needs and communicate about this. It's the grown-up thing to do. Stealing sex is juvenile; children steal when they want something and can't get it any other way. Stealing sex is also criminal. Rather than feeling good afterwards, in your private thoughts you feel dirty – even if your friends did give you a high-5. Despite the high-5s, it's hard to feel proud of yourself; only you know in your private thoughts that you had to steal sex to get it.

As a caveat, be mindful that some clients, those that present as narcissistic and other psychopathic traits, along with an alleged offense that has many antisocial elements, are likely to play along with you, entertain you, and convince you of their inherent goodness. Expecting them to express any genuine feelings will be unrealistic. Expecting them to discuss their interpersonal attachments may be futile. The most important suggestion is to keep your eyes wide open and not be fooled by the guile, the ruse, the jive, the artifice, the run-around that characterizes the very few clients that present with psychopathic features. If indicated, document observations in progress notes, and consider a referral for longer term treatment as we suggest in the intro.

→ Session Introduction:

- A critical part of treatment will be to move from the abstract to the personal and discuss the importance of the quality of the client's relationships (e.g., what is love about in

relationships you have had)? It is not about lust, and it is not only about sex. It is about developing an attachment to another human being. This will inevitably bring up discussion about the contemporary culture of unattached casual sex – friends with benefits, hookups, etc. More to the point, however, is some unusual soul-searching about what it means to the client to be a man or to be masculine; this is not something that men typically think about other than referentially (i.e., it means being like Sylvester Stallone or Peyton Manning). Let's talk just about you, not an actor, not an athlete, just you. Stallone is an actor playing a role; he has a screen persona. We have no idea what he is like as an individual. We are here to better understand your persona, what qualities you aspire to have as a man.

- Healthy men should no more have to steal sex than steal a quart of milk from the market. Men that must resort to stealing sex are insecure. Healthy men are confident – at their core they have self-esteem; they are self-assured, qualities that women admire. Men that are socially successful, the guys in high school that were most popular with the girls, are not successful because they must "take" what isn't offered; they are successful because they exude confidence and are offered what they receive.

- The confidence that comes with healthy masculinity means using your power and your strength and your conviction for the right reasons. It means standing up for the underdog, not taking advantage of the underdog; it means standing up for victims, and if necessary protecting victims, not creating victims. Men of honor and integrity do not create victims. In the fictional world, our heroes and super-heroes protect victims. And in the real world as well, we pay our greatest homage to those heroic souls that defy all odds to protect those in danger (e.g., "9/11"). We have no record of paying homage to those that intentionally place others in danger or harm's way. Those who harm others do not deserve respect and honor.

- Having internal strength, fortitude, backbone, moxie, grit, mettle, valor, tenacity, and courage are characteristics of strong, healthy men. It takes considerable courage to look yourself in the mirror and own who you are, for all your strengths and your weaknesses. It takes courage and honesty to look yourself in the eye and ask whether you are proud of the decisions you have made. Puffing out your chest filled with nothing more than hot air is what clowns do in the circus; it is also what narcissists do. They puff themselves up to compensate for all their inadequacies. Healthy self-assured men have no need to brag, to boast, or to be arrogant.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Session Objectives/Content/Activities:

- Have the client spell out what for him constitutes healthy and unhealthy masculinity.
- Have the client give examples from his own life of things he did or said that reflected healthy and unhealthy masculinity.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- These are intended to be Out-of-Session Activities with an assignment to bring into session a "reaction" paper, or some similar documentation of thoughts, and feelings about the video, Ted Talk, Power Point presentations, or attitude scale, etc. PowerPoint presentation of quotes of politicians about women.
    - PowerPoint presentation of quotes of politicians about women.
    - Have the client complete a rape myth scale. Discuss with the client "attitudes" from one or more of the many rape myth / cognitive distortion scales and discuss his own myths / attitudes.
    - Have the client complete one of the many scales on stereotypic characteristics of hyper-masculine men and discuss which he identifies with.
    - Have the client watch one of the excellent YouTube videos from athletes and soldiers, such as:
        i. Male athletes against violence: https://www.youtube.com/watch?v=-I7UAtd2h88
        ii. Cadets against violence: www.youtube.com/watch?v=VYzy6gsCqnE
        iii. Jackson Katz video: https://www.youtube.com/watch?v=ElJxUVJ8blw

- **The clinician could intentionally espouse sexist attitudes, even far-fetched sexist attitudes, get the client to disagree, get him to defend his opinion that the clinician's attitudes are "wrong" or don't 'make sense'; get the client to challenge the clinician. <u>The clinician should follow up by making this deception known and explaining its intent.</u>**

- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

- **Have the client:**
    - Prepare a list of: all of the women that have been president or prime minister of a country and which country. Point out the several dozen Muslim countries where women have been prime minister; in fact, the longest serving female prime minister in the world was not only in a Muslim country but in one of the poorest countries (Bangladesh);
    - Prepare a list of all the women that have won the Nobel Prize in science (or other areas) and what they did;
    - Prepare a list of women that have recently or now head up the largest multi-national corporations in the world; point out people like Ginni Rometty, the CEO, President and Chairwoman of IBM, one of the world's largest companies with well over 100 billion in assets;
    - Prepare a list of women who have risen to the rank of general in the Armed Forces, or women combat soldiers that performed heroically, like Tammy Duckworth, an Army helicopter pilot who suffered severe combat wounds and lost both of her legs in Iraq, or the women who recently were admitted to the Army Rangers;
    - Look at the male and female athletes winning Medals at the recent 2016 Summer Olympics: women – 61 medals, men – 55 medals; women – 27 Gold Medals, men – 19 Gold Medals. If the American men had never attended the Olympics and the U.S. was represented ONLY by the women athletes, the U.S. women's 27 Gold Medals alone would have tied Great Britain for 1st place ranking in the world among nations receiving Gold Medals.

- **Additional Excellent YouTube Ted Talk Resources:**
    - Other great Ted Talks on Healthy / Unhealthy Masculinity to consider:
        - https://changefromwithin.org/2013/11/21/please-be-that-guy-7-men-who-are-transforming-masculinity/ -- 7 men who are transforming masculinity -- Darnell Moore, Fivel Rothberg, Kai M. Green, Emiliano Diaz de Leon, Jackson Katz [It's a men's issue – below], Jeff Perera, Carlos Andres Gomez,
        - https://www.youtube.com/watch?v=LBdnjqEoiXA -- "Unmasking masculinity" – Ryan McKelley
        - https://www.youtube.com/watch?v=umKKrbmdHFM
        - https://www.youtube.com/watch?v=jVI1Xutc_Ws -- "Be a Man" - Joe Ehrmann

- https://www.ted.com/talks/zimchallenge?language=en -- "The Demise of Guys?" – Philip Zimbardo
- Play List – 5 talks on How Masculinity is Evolving: https://www.ted.com/playlists/404/how_masculinity_is_evolving

  1. Michael Kimmel: Why Gender Equality is good for everyone – men included
  2. Tony Porter: A Call to Men
  3. Colin Stokes: How movies teach manhood
  4. Jackson Katz: Violence against women – it's a men's issue
  5. Elizabeth Nyamayaro – An invitation to men who want a better world for women

→ Check Out (5-10 min):

- **Ask the client to answer one or more of the following questions:**
  - What did you think about today's discussion about negative/hostile masculinity?
  - What were some things you found useful in today's session? What wasn't useful?
  - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

MODULE 6

Consequences of Sexual Abuse & Effects of Sexual Misconduct on Victims/Survivors and Others

Consequences of Sexual Abuse

Clinician Note:

A primary goal of this Module is to help the client truly experience an emotional awareness of victim impact and the harm caused by the client's behavior. As such, the session may become emotional as the client recognizes and feels an array of emotions related to the harm the client caused. The clinician will need to monitor these emotions and address them as indicated. Such feelings may be exacerbated when the client has been a victim of sexual abuse or other forms of violence.

It is important to help the client understand the impact of sexual abuse on the victim, others and/or self. Empathetic understanding may be incompatible with mistreating and abusing others, and is a goal of this Module. Material from Session 1 and Session 2 can be combined or used in any order depending on the clinician's judgment of what is best for a particular client.

- In some cases, the client may display substantial lack of empathy or perspective taking. If the clinician considers this problem a function of personality dysfunction or perhaps another psychological impairment that impacts the client's ability to take others' perspectives or empathize with them, the clinician may decide to emphasize tangible concrete consequences to the victim/survivor and the client, rather than attempt to affect an emotional understanding and empathy.
- Sometimes when a client is making treatment gains and starting to exhibit intense feelings of guilt or remorse additional support and help developing additional coping strategies may be needed. Be sure to assess for potential suicidal and other violent ideation.
- In addition, if the client is having a difficult time regulating the emotions that are raised during this module (or other sessions as well) the clinician may want to introduce additional emotional regulation strategies.
- If the client also was sexually abused and is experiencing this module from dual perspectives (i.e., victim/survivor and perpetrator of the misconduct), and is experiencing strong reactions, these too may require clinical attention.

SESSION 1: **IMPACT OF SEXUAL MISCONDUCT**

Session Goals

- Help client develop an understanding of the impact sexual misconduct and abuse can have on victim/survivors.
- Facilitate appropriate empathy and regret for harm done.

Session Objectives

- Without embarrassing and/or shaming, this session is intended to help the client understand the potential effects of sexual abuse on victim/survivors.
- Develop or increase awareness of the effects of sexual misconduct on victim/survivors and facilitate empathy to those harmed by sexual misconduct.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Explore the potential impact of sexual misconduct on the victim/survivor from multiple perspectives – psychological, social, financial, etc.
- Discuss possible immediate, short, and long-term effects.
- Facilitate awareness and empathetic understanding through therapeutic activities

→ Possible Activities:

- View a victim impact video with the client that demonstrates a range of the possible traumatic effects of sexual misconduct. Select one that allows sufficient time to discuss and process the client's thoughts and emotional reactions to the impact of sexual misconduct as evidenced in the videos. Possible videos to consider include:
  - Victim Perspective STARRSA video
  - Morgan extended video WastedSex.com
  - Until it Happens to you by Lady Gaga https://www.youtube.com/watch?v=ZmWBrN7QV6
  - See Appendix F for additional options
- Select one or more victim impact vignette for discussion and exploration. (Victim Impact Vignettes are located in Appendix F).
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.
- Have the client watch some of the following student discussions with Dr. Abrams and log his/her reactions.
  - Who is impacted by sexual assault?
  - Impact of sexual assault
  - Consequences of sexual assault
  - Facts about sexual assault Part I and II

→ Possible Out-of-Session Assignments (OSAs):

- Ask client to log any thoughts/feelings about today's session and the potential effects of sexual misconduct during the upcoming week.

- Have client think about the video viewed during session and write a list of all possible consequences for the survivor in the video (shown and not shown), and how others may have been affected as well.

    - Or watch other victim impact videos or movies such as the those on WastedSex.com and write down details regarding their reaction, (e.g., Dr. Marilyn Kaufhold) (Consider any concerns about the client viewing such material out of session).

- Give the client the two handouts (see links below) and ask them to provide a brief summary and conclusion about sexual misconduct/abuse based on these two handouts.

    - http://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf

    - http://sapars.org/Sexual%20Violence%20%20Effects,%20Costs%20and%20Prevention.pdf

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client what this session was like for him/her. Spend time processing reported feelings of guilt, shame, and so forth.

- If there are indications of a lack of remorse or that the client is only concerned or feeling bad about the fact that the client was found responsible, additional interventions that attempt to elicit at least a cognitive appreciation of the harm sexual misconduct can cause may be required before moving on.

- Introduce next week's topic.

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

- **Handouts:**
    - http://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf
    - http://sapars.org/Sexual%20Violence%20-%20Effects,%20Costs%20and%20Prevention.pdf

SESSION 2: **EFFECTS OF SEXUAL MISCONDUCT ON VICTIM/ SURVIVORS AND OTHERS**

Session Goals

- Help client develop a deeper understanding of the impact sexual misconduct and abuse has on victim/survivors as well as others (i.e., friends, family, community & oneself).
- Help the client appreciate the impact or likely impact to Complainant (the person who the client was found to have sexually mistreated) of the sexual misconduct. Facilitate an increased understanding and empathy for the Complainant at an affective level.
- Without embarrassing and/or shaming, this session is intended to help the client understand the multiple effects of sexual abuse in addition to the victims/survivors. The ripple effects sexual misconduct has on others.

Session Objectives

- Enhance the client's perspective taking, level of empathy, and remorse for all victims/survivors of sexual misconduct and address any problems with such.
- Facilitate awareness of and empathy to others harmed by sexual misconduct, in addition to victims/survivors, e.g., family, friends, community).
- Increase an understanding of the consequences of sexual misconduct to the people responsible for such behavior.
- Increase understanding of how the client's behavior and the ramifications thereof have impacted the client's life in the short and long term.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Assess for potential problems with perspective taking and empathy and employ corrective strategies, e.g., engage client in exercises that facilitate perspective taking.
- Engage the client in activities that may facilitate improved affective understanding of and empathy for victims/survivors (e.g., through activities that provide the perspectives of people who have been hurt by sexual misconduct).
- Continue to facilitate empathy for the victim/survivor's perspective.
- Help the client appreciate the impact or possible impact of the sexual misconduct on Complainant in the case or cases for which the client was found to have engaged in sexual misconduct
- Explore the impact of sexual misconduct on secondary victims of sexual misconduct (e.g., friends, family members, and the school community); discuss immediate, short, and long-term effects.
- Discuss the impact of the sexual misconduct to the person found responsible, emphasizing consequences, but also how this knowledge can be used positively in the future.

→ Possible Activities:

- Review with the client the potential effects of different types of sexual misconduct (e.g., psychological, social, financial, etc. building on the previous session).

- **Help the client brainstorm how sexual abuse impacts friends and families of the victim/ survivor. Have client discuss the potential immediate, short-, and long-term effects. For example, the friends and family:**
    - May have similar trauma reactions if the person is close.
    - May feel incapacitated, helplessness, or guilt for thinking they should have been able to protect the Complainant
    - May be triggered if they were victims themselves
    - May have anger reactions/revengeful reactions
    - May need help/support

- **Brainstorm with the client how sexual misconduct impacts the community. Encourage the client to discuss the potential immediate, short, and long-term effects. Discuss the examples that they have brought in from their Out of Session Assignment (OSA).**
    - Cost
    - Resources
    - Fear, concern

- **Assist the client in identifying how sexual misconduct impacts those responsible. Discuss the potential immediate, short, and long-term effects. Ask the client to discuss how sexual misconduct allegations may impact the person who was accused. Using the examples that the client has brought in from the OSA, discuss the effects on the person accused of or responsible for the sexual misconduct/abuse.**

- **Ask the client to discuss how being accused and found responsible for sexual misconduct has personally impacted him/her. The clinician can empathize with the client's personal difficulties but also will assess the client's understanding of the consequences of engaging in sexual misconduct and support the client's expressions of remorse and regret, and encourage the client's plans to ensure such behavior is not repeated.**
    - Discuss with the client how this situation has specifically impacted his/her life. Explore the impact across various areas of life.
    - If there have been any retaliatory effects from the victim, friends, etc., discuss how the client has felt and managed these emotions.
    - If people do not know about the sexual misconduct, what concerns does the client have about how others would react if they found this out about his/her behavior?
    - Encourage the client to begin thinking about how to prevent sexual misconduct in his/her own life as well as to help others.

- Consider relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Instruct client to create a list of all people harmed by the client's behaviors that led to a student conduct finding of sexual misconduct and any similar behaviors the client believes relevant. own sexual misconduct, including the instant offense and other similar behavior (As noted previously, to protect the client's right to not incriminate him/herself, details of the behaviors and identifying information regarding those harmed should not be included).

- Suggest the client write statements expressing amends. The client should NOT use names or identifiers, or contact the victim/survivor. The purpose of this exercise is to increase the client's understanding of harm done and express related feelings. The statements should not be sent to anyone, but be brought to therapy only. The client is not required to describe the sexual misconduct to complete this assignment.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client what this session was like for him. Spend time processing feelings of guilt, shame, and so forth.
    - How was this session compared to last week?
    - Ask the client to identify and discuss emotions evoked during this module.
    - Ask the client what the most emotionally evocative part of the session was and why they think that it was so poignant for them.

- Introduce next week's topic.

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

- **Handouts:**
  - http://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf
  - http://sapars.org/Sexual%20Violence%20-%20Effects,%20Costs%20and%20Prevention.pdf

MODULE 7

Behavior is a Choice: Choosing Wisely

Behavior is a Choice: Choosing Wisely

SESSION 1: THE ABCS OF HUMAN BEHAVIOR

Session Goals

- Develop an understanding of the antecedents and consequences of choices and decision-making.
- Practice using a five-step model for decision making.

Session Objectives

- Help the client understand how they make choices and decisions.
- Discuss the antecedents and consequences of choices that he/she has made.
- Discuss how emotional states and thoughts affect behavior.
- Build effective decision-making skills.

Principal Contributor: Becker

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Discuss how individuals begin making choices at very early ages (e.g., a child choosing whether to listen to a request a parent has made, choosing what food to eat, what clothes to wear, etc.). As the individual matures they make choices regarding what course subjects to take, what their life goals are, who their friends will be, who they choose to enter a relationship with, what their occupation will be, or what university to attend.
- Assist the client in identifying emotions and thoughts that have led the person to engage in non-consenting sexual behavior (sexual misconduct). Explain: "It is important to learn how to regulate those emotions, thoughts, and behaviors that put you and others in harm's way. This involves developing adaptive skills as opposed to the maladaptive thoughts and behaviors you have engaged in."
- Discuss how some choices or decisions have a positive effect on the individual and on others, while other decisions have a negative/harmful effect on the individual and on others.
- Define antecedents and consequences of behavior. There are antecedents and situations that occur prior to a person making a choice, the person then makes the choice (behaves), and then some positive or negative consequences may ensue relative to the choice made.
- Explore factors that affect choice/decision making. They include some of the following: a person's past experiences, his/her past choices (have they had positive or negative outcomes), and the particular situation the person is in (contextual factors). The person's current emotional state can also affect choices (anger, intoxication, depression, joy, love, impulsiveness). Momentary urges may also play a part, as well as expectations, opportunity, and support, or lack thereof, for a choice and how others may view you. Factors can differ by salience and perceived importance and may be weighted differently in the decision-making process. Explore - what might influence the salience or weight of factors?

→ Possible Activities:

- Present the client with unidentified myths and facts about sexual misconduct on campuses. Have the client rate them as true/false; correct errors and discuss.

- Have the client list in writing the risks and benefits of sexual misconduct. If hesitant, assist and then help the client critically evaluate the list.

- Building on previous sessions, have the client name as many attitudes and beliefs that some people have that support sexual misconduct while clinician scribes. Next, discuss which of these attitudes and beliefs the client thinks are valid. Ask the client whether any of these beliefs may have negatively influenced him/her and contributed to his/her sexual misconduct.

- Next, ask the client to brainstorm evidence in opposition to these attitudes and beliefs as the clinician scribes. If the client has difficulty identifying prosocial attitudes, beliefs, and behavior in opposition to those that support sexual misconduct, provide information and evidence demonstrating that most people do not have such attitudes and beliefs.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Brainstorm how individuals make choices.

- Review the cognitive triangle (ABC Model).

- Introduce and practice steps to good decision-making.

- Introduce and practice emotion regulation skills, e.g., focused breathing.

- Other exercises may include reviewing choices the client has made in his/her life and the effects it has had on them and others. For example, using the cognitive triangle to identify antecedents, behaviors, and consequences of situations that did not work out well. Then review the situation and employ new decision-making skills that might have led to better outcomes, such as:

    - Identify risky versus protective antecedents;

- Slow down (relax);
- Evaluate options;
- Pick one and consider possible consequences before acting.

- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- **Instruct the client to use information and decision-making skills to evaluate two significant life decisions (one positive and one negative choice).**
- **Assign the client daily practice of one or more emotion regulation skills.**
- **Encourage the client to practice good decision-making skills in day to day life and write down several detailed examples for discussion next week.**
- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- **Ask the client what this session was like for him. Spend time processing feelings of guilt, shame, and so forth.**
  - What were some things you liked about today's session? What didn't you like?
  - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
  - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?
- **Introduce next week's topic.**

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 2: **MY VALUES AND GOALS: WHO I AM AND WHO I WANT TO BE**

Session Goals

- Help the client develop an understanding of what values and goals are in general and what the client's individual values and goals are. Help the client recognize that she/he can get back on track.

Session Objectives

- Help the client define values and goals.
    - **Goals of treatment – review what he/she wanted to get out of treatment, and what else can he/she get out of treatment that would be helpful to his/her psychosocial development.**
    - **Goals for when he/she return to school, if he/she are out.**
    - **Immediate goals after they graduate.**
    - **Long term life goals (what do they want in life).**
- Learn where values and goals come from and how they develop.
- Assist the client in identifying his/her own values and goals and how poor decision-making contributed to his/her current situation (e.g., sexual misconduct, suspension, other consequences).
- Help the client recognize how good decision-making is consistent with his/her values, life goals, and objectives.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Discuss the definition of value with the client. A value is a person's principles or standards of behavior; one's judgment of what is important in life.
- Discuss how individuals develop their values. Many young people adopt their parents' values, such as the importance of education or a religious/spiritual life. To be kind to others is important. Other parents may have values such as "win at all costs", "do unto others before they do unto you." Not all parents have the same values. Consequently, a youth may adopt or reject both parents' values, accept one and reject the other, or may develop values learned from peers or others in their life. Our values determine how we think, act, and present ourselves to the world.
- Explore why having values is important. An important question every person should ask themselves based on their values and behavior is: "Is this how I want to present myself to the world?"
- Discuss with the client what a goal is and how it differs from a value. A goal is something one wants to achieve, an object of one's ambition or effort. Examples of some goals are: to successfully complete college, to have a profession, to have a partner, to have children, to contribute to society, to help those in need, to always be grateful to those who have helped me, not to hurt others.
- Help the client evaluate if his/her school behavior and experiences are consistent with his/her values.
- Explore the client's risky behaviors in the context of the client's goals and values. Shift to a motivational interviewing approach, if indicated.

- Have client identify long terms life goals – what do he/she want from life, what do he/she envision?
    - Does this include a partner, children, and friends?
- What are the things he/she value, what type of person do he/she aspire to be?
- Does sexual misconduct behavior fit in with any of this? How does this behavior impact their ability to attain these goals?
- How has this behavior changed their goals?

→ Possible Activities:

- Briefly discuss examples of the client's goals. Which ones have been achieved? What have been the obstacles to achieving them? What or who has been of assistance in achieving them?
- Help the client identify his/her emotions and thoughts in response to facing obstacles and then identify strategies for dealing with obstacles, and strategies for regulating their emotions and thoughts when faced with obstacles so they are not stuck or making poor decisions or engaging in risky behaviors.
- Brainstorm with the client how his/her student conduct violation and sexual misconduct were consistent or inconsistent with his/her values and goals.
- Brainstorm with the client what obstacles interfered with achieving their goals and realizing their values. Using the problem-solving model that was discussed in the prior session, select an obstacle and use this method to generate solution (or something to this effect).
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Have the client draft a values, goals, and objective statement that demonstrates how she/he wants to live his/her life (especially regarding his/her relationships with peers,

friends, family, fellow students, and co-workers) and how he/she want to conduct themselves when engaging in potential or actual intimate relationships, as well as why.

- Ask the client to demonstrate his/her increased understanding of how he/she can use his/her values to guide them, expect and prepare for obstacles and risks, and employ good decision-making.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client what this session was like for him/her. Spend time processing feelings of guilt, shame, and so forth.
    - What were some things you liked about today's session? What didn't you like?
    - Name some things you haven't thought of before that we talked about today or something that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 3: **RECOGNIZING AND MANAGING RISKY THOUGHTS, FEELINGS, BEHAVIORS, AND SITUATIONS**

Session Goals

- Identify risky (maladaptive) thoughts, feelings, behaviors, and situations that can lead to non-consenting behaviors (sexual misconduct) and developing effective management strategies.

Session Objectives

- Help the client identify their emotions, thoughts, and circumstances that lead to maladaptive behaviors and sexual misconduct.
- Help the client identify, develop, and enhance skills to effectively manage risky thoughts, feelings, behaviors, and situations.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Review some basic emotions including: happiness, sadness, anger, fear, surprise, disgust, shame/guilt, love/interest, and how thoughts can generate one of these emotions and conversely these emotions can affect our thinking and behavior.

- Help the client identify situations where he/she have experienced these emotional states and the intensity of them. Explore how the client has learned these emotional states.

- Assist the client in recognizing the specific signs that he/she are experiencing these emotions (including physiological cues).

- Help the client identify specific maladaptive thoughts related to sexual misconduct.

- Assist the client in identifying emotions and thoughts that have led to non-consenting sexual behavior. Note: It is important to learn how to regulate those emotions, thoughts, and behaviors that put you and others in harm's way. This involves developing adaptive skills as opposed to the maladaptive thoughts and behaviors you have engaged in.

- Help the client understand that maladaptive behaviors, such as having sex without consent, can be regulated by monitoring urges and physiological states (e.g., intoxication, increased sexual arousal).

→ Possible Activities:

- Brainstorm with the client some basic emotions including: happiness, sadness, anger, fear, surprise, disgust, shame/guilt, love/interest. Our thoughts can generate one of these emotions and conversely these emotions can affect our thinking and behavior.

- Help the client identify situations where he/she have experienced these emotional states and the intensity of them. Does she/he experience them at different times and in different situations? How have they affected his/her thinking? For example, has he or she ever felt angry and then given his/herself permission to think less of a person or have harmful thoughts towards a person because of anger? If so, identify how that influenced his/her behavior toward that person.

- Brainstorm with the client specific signs that he/she are experiencing these emotions (including physiological cues).

- Discuss how risky thoughts may influence non-consenting behavior. For example, a person may feel deserving of sex and entitled to it and, therefore, justifies his/her coercive sexual behavior. Ask, specifically, "What risky thoughts have you had that have put you or another person in harm's way?" "What emotions accompanied those thoughts and what behaviors?" (Remind the client she/he is not being asked to disclose behaviors that may incriminate him/her in ways that could be used against them in later legal proceedings).

- Help the client identify specific maladaptive thoughts that support sexual misconduct. For example, discuss that she/he is in this program because of thoughts that led to behaviors that resulted in the person being found responsible for doing harm to another person and ultimately to him/herself. Ask: "How did you give yourself permission to engage in non-consenting behavior?" The first step in changing risky thoughts and behavior is to monitor them.

- Review significant past decisions and choices that the client has made in his/her relationships with others and what emotions and thoughts accompanied them. What were the consequences of the choices she/he made? Ask the following:
    - How did others view those choices?
    - Have you taken time to obtain feedback on the way you think and on your behavior?
    - If not, suggest: It might be helpful to do so now.

- Assess for openness and receptivity to feedback and acceptance of actions and behaviors.

- Discuss how maladaptive thoughts and feelings can be regulated. Regulation of maladaptive feelings and risky thoughts involves some of the following:
    - Self-monitoring
    - Distracting yourself from your thoughts
    - Considering the pros and cons of dwelling on the risky thought
    - Engaging in self-talk and self-encouragement to discourage a particular thought and replace it with a more adaptive one.

- Emphasize: "It is important to learn how to regulate those emotions, thoughts, and behaviors that put you and others in harm's way. This involves developing adaptive skills as opposed to the maladaptive thoughts and behaviors you have engaged in."

- **Facilitate client's understanding that maladaptive behaviors, such as having sex without consent, can be regulated by monitoring urges and physiological states (intoxication, increased sexual arousal). Brainstorm ways to monitor and manage physiological states and urges. Help client list possibilities. Some possibilities include:**
    - Identifying a sexual urge as a simply a feeling or impulse that will pass; something the client has the capacity not to act upon.
    - Distracting him/herself from the urge by doing something inconsistent with the impulse, such as removing him/herself from the situation or joining a game of basketball.
    - Considering the impact that acting on an inappropriate urge will have on another person and on the client; and tie to decision-making process.
- **Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.**

→ Possible Out-of-Session Assignments (OSAs):

- **Have client complete a Functional Behavior Analysis (FBA) diagram identifying the event/ situation that occurred, their thoughts and emotions, and the choice they made.**
- **Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- **Ask the client what this session was like for him/her. Spend time processing feelings of guilt, shame, and so forth.**
    - What were some things you liked about today's session? What didn't you like?
    - Name some things you haven't thought of before that we talked about today or something that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?
- **Introduce next week's topic.**

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

MODULE 8

Healthy Relationships

Healthy Relationships

SESSION 1: **FRIENDSHIPS AND PARTNERS**

Session Objectives

- Assist the client in defining what a relationship is.
- Describe the different types of relationships a student might have had in the past, at present, or wish for in the future.
- Clarify what makes for a healthy and unhealthy relationship.
- Why are relationships important? Why are social relationships and having connections to others important? How are they helpful and useful for us?

Session Goals

- Using information learned thus far, help the client describe the different types of relationships and what defines healthy relationships. Focusing on:
  - **Friendships and partners**
  - **What are healthy relationships?**
  - **Taking Stock: expectations, hopes, and goals**

Principal Contributor: Becker

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Review with the client the different types of relationships he/she have, including relationships with his/her family members, peers, acquaintances, faculty, and employers.
- Explore relationships that he/she have had that involved sexual intimacy (including committed relationships, hook-ups, etc.).
- Explore relationships he/she have valued that were without sexual intimacy.

→ Possible Activities:

- Encourage the client to brainstorm attributes of healthy relationships (e.g., trust, compassion, respect) and unhealthy relationships (e.g., jealousy, distrust, coercion). Discuss whether various behavioral examples are signs of caring and healthy relationships (e.g., advising which clothes are acceptable to wear, reading the other person's text messages, insisting on sharing of passwords to social media, disallowing hanging out with other people, etc.). What is a healthy versus unhealthy relationship?
- Ask the client to provide examples of healthy and unhealthy relationships in their life, or aspects thereof and assist in clarifying the difference between the two.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

Clinician Note

It is possible that given that rapport is now established with the client, the client may be open to discussing his/her own abuse history - if such a history exists and it is useful for the client's treatment at this time.

→ Possible Out-of-Session Assignments (OSAs):

- Ask the client to observe and jot down examples of healthy and unhealthy relationships during the week, for example from social media, literature, movies, or music or everyday life.

- Encourage the client to review selected videos such as Dr. Abram's videos on relationships and dating.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client what this session was like for him/her. Spend time processing feelings of guilt, shame, and so forth.
    - Were there things you haven't thought about before that came up today?
    - Is there anything that stands out? How may this be helpful to you in your life?
    - Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 2: **PERSPECTIVE TAKING AND EMPATHY: UNDERSTANDING AND CARING ABOUT THE NEEDS, WANTS, AND FEELINGS OF OTHERS**

Session Goals

- Increase an understanding of what perspective taking is, and understanding another person's point of view and needs.

Session Objectives

- Assist the client in looking at his/her basic beliefs about people.
- Facilitate perspective taking.
- Facilitate active listening skills.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Observing and getting to know other people's interests, values, and goals.
- Learning how a person's beliefs and expectations can affect behavior.
- Helping the client explore the role of empathy in relationships, in general and in his/her life.
- Identifying the core characteristics of different types of successful relationships. What are the overlapping characteristics, what are the different characteristics? Can use to discuss appropriateness of sexual and nonsexual forms of expression with different people while touching upon consent.
- Introduce steps of active listening skills and practice.

→ Possible Activities:

- Review active listening (what it is and how to do it) and role play how to put oneself in another's shoes.
- Practice strategies to learn how others think and feel.
- Brainstorm with the client what things are most important to people, relating this to values and goals in previous module: What sort of things are people proud of? What sort of things do people like and dislike?
- Have the client discuss what she/he likes about others in comparison to himself.
- Discuss who has cared for him over the course of his life and who he has cared for. What does that feel like (Heard, understood)?
- Ask the client to define empathy and request examples of when she/he has experienced it and when he has demonstrated it. Improve upon client's definition as needed.
- Discuss what the client's expectations are about relationships. Explore expectations of his/

her family members, friends, acquaintances, strangers, romantic and sexual partners, and employer. Where does empathy fit?

- Ask, explore, and practice how one determines what another person's likes, dislikes, wants, needs, and feelings are.

- Brainstorm with the client: How can you demonstrate that you care for someone? Request the client give specific examples. Review and discuss which of these are healthy/unhealthy and why.

- Discuss how the client likes to be treated in a relationship and use this as fodder for a discussion of relationship roles and expectations.

- If the client engages in or would like to engage in sexual hook-ups, explore how basic respect for another person can be demonstrated, even if they are trying to limit the emotional connection and have no interest in an ongoing relationship and how to ensure they understand the other's perspective. Discuss why this is important (e.g., abusive situations can result when people don't specifically ask the partner in the "hook up" about consent, what they like, if something hurts, etc.).

- Introduce Active Listening skills.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Suggest that the client practice active listening skills with a family member or friend, as well as practice using the skills in day to day interactions. Encourage the client to bring in observations, questions, or comments.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- **Ask the client to answer one or more of the following questions or alternative check out questions:**
    - What was something new that you learned today or that stands out? How it may be helpful to you in your life?
    - How has our time today together been helpful? Is there anything else that we didn't get to that you think would have been helpful?
    - think would have been helpful?
- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

SESSION 3: **COMMUNICATING EFFECTIVELY: INTERPERSONAL AND DATING SKILLS**

Session Goals

- The major goal is for the client to promote positive interpersonal skills and facilitate healthy, respectful relationships and intimacy through effective communication.

Session Objectives

- Impart knowledge regarding good communication skills.
- Discuss how communication involves a lot more than imparting information.
- Link active listening skills and empathetic perspective taking and understanding to establishing healthy new relationships and respectful intimacy.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Communication involves fully focusing one's attention the other person.
- Communication involves not only listening to what is said but understanding the emotions behind the words, as well as the intentions.
- Discuss the importance of body language when communicating, possibly using visual aids (e.g., pictures or video clips).
- Discuss the fact that people from different cultures and family backgrounds may have different ways to communicate.
- Develop an understanding that one's communication may vary when under stress or under some other emotional state, such as intoxication.
- Discuss the issue of the evolution of "dating" over the years. Now, some young adults develop serial or concurrent short-term relationships, others have long-term relationships; there are also those individuals that have "hook-ups" and friends with benefits.
- Discuss how communication may vary based on the type of relationship one is in.

→ Possible Activities:

- Identify characteristics of good communication and apply them to different situations.
- Brainstorm with the client the difference between flirting and sexual harassment.
- Practice active listening skills by using example situations from everyday life.
- Discuss/review video clips or role play (if appropriate) how to ensure flirting is respectful and appreciated and not offensive.
- Discuss/practice how to use active listening skills to recognize cues from the person receiving the flirtation (e.g., someone may think they are flirting, but the person on

the receiving end receives it as harassment). Explore: How to know when the cues you are sending are unwanted, and how to know when to stop (Active listening, asking for feedback)?.

- If the person engages in hook-ups, discuss how active listening, communication, and feedback is important in such situations.

- Role play asking someone out on a date. Feedback on one's communication skills is imperative. Role play asking for feedback.

- Practice Active Listening skills.

→ Possible Out-of-Session Assignments (OSAs):

- Have the client practice active listening and perspective taking skills in various relationships (e.g., a friend, a boss, family member, etc.) and complete a work sheet that documents:
    - The type of communication skill.
    - For each skill – list the response, whether it was it effective, why/why not, and the outcome.
    - What was challenging.
    - What else s/he could have used in that situation, (e.g., asking for feedback).

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful? Is there anything else that we didn't get to that you

think would have been helpful?

- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

SESSION 4: **DEVELOPING POSITIVE RELATIONSHIPS**

Session Goals

- Develop positive relationships that reflect equality and compromise rather than gender-stratified roles, obligations, and expectations or that are one sided, inequitable dynamics based on dominance.

Session Objectives

- Impart information about how society, for the most part, has changed from decades ago, where individuals were locked into certain roles which were not healthy for males and females.
- Facilitate understanding that healthy relationships are ones of equals where compromise occurs.
- The client learns that gender stereotypes are damaging to both males and females.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- Discuss what gender and gender roles mean.
- Review evolution of sexual discrimination.
- Discuss different forms of harassment (e.g., quid pro quo, hostile work environment). Of note, 80 percent of student in a Forensic class (200 students) reported they knew someone who had been harassed.
- Discuss how the client sees himself/herself as men/women or an alternative gender identity, specifically how do he/she want to present himself/herself to the world.
- Discuss various types of sexual discrimination (e.g., harassment, exploitation, abuse of individuals identifying or presumed to be LGBTQ).
- Discuss the concept of fairness in human interactions.
- Explore how these concepts and concerns relate to the client and his/her life.

→ Possible Activities:

- If this has not already been covered, briefly review evolution of sexual discrimination.
- Explore what the client can do to facilitate more equality and fairness in campus relationships.
- Review the client's relationships and how they have and have not reflected equality and mutuality, and benefited each other, or not and what s/he wants for the future.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Ask the client to observe interactions in daily life, music, or the media that reflect sexual discrimination, the observed or possible impact it has on those discriminated against, as well as efforts done, or what could be done to correct such discriminatory behavior.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
    - What were some things you liked about today's session? What didn't you like?
    - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
    - How has our time today together been helpful?
    - Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 5: **HOW DOES SEX FIT IN MY LIFE?**

Clinician Note

Direct, open, and honest discussion is imperative. The client should be assured that there is nothing wrong or immoral about having sex, and, moreover, that women as well as men enjoy having sex too. Sex can be a lot of fun and feel good for both people, but only when both people want it, and it is fully consenting. Only then is it fun. Guys have to learn to talk about it; women will respect a man for being able to listen to her needs and communicate about this. Women also have to learn to talk about it, and communicate their needs and wants too. It's the grown-up thing to do. Stealing sex is juvenile; children steal when they want something and can't get it any other way. Stealing sex is also criminal. Rather than feeling good afterwards, in your private thoughts you feel dirty – even if your friends did give you a high-5. Despite the high-5s, it's hard to feel proud of yourself; only you know in your private thoughts that you had to steal sex to get it.

Session Goals

- Assist the clients in understanding his/her values, attitudes, and feelings about sex.
- Address where those values, attitudes and feelings emanated from.
- Discuss safe sex practices, including how to ensure consent.

Session Objectives

- A major objective is for the client to articulate his/her values regarding sex and increase his/her ability to put them into practice.
- The client will be able to describe/discuss his/her attitudes about past sexual behaviors that he/she feel were healthy and those that he/she now feel were not healthy.

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Assist the client in reviewing past sexual behaviors that were healthy and those that were not, and use CBT skills to identify risk factors (antecedents) and what they could have done differently (e.g., avoiding high risk situations, perspective taking, problem solving, etc.).
- Assist the client in reviewing and implementing the CERTS[1] model.
    - **CONSENT** means you can freely and comfortably choose whether or not to engage in sexual activity. You are able to stop the activity at any time during the sexual contact.
    - **EQUALITY** means your sense of personal power is on an equal level with your partner. Neither of you dominates the other.
    - **RESPECT** means you have positive regard for yourself and for your partner. You feel respected by your partner.
    - **TRUST** means you trust your partner on both a physical and emotional level. You have mutual acceptance of vulnerability and an ability to respond to it with sensitivity.
    - **SAFETY** means you feel secure and safe within the sexual setting. You are comfortable with and assertive about where, when, and how the sexual activity takes place. You feel safe from the possibility of emotional and physical harm, including unwanted pregnancy, sexually transmitted infection, and physical injury.

    ! Wendy Maltz, LCSW.

→ Possible Activities:

- Ask the client to describe what defines consent and the CERTS model. Ensure client can

clearly delineate who can consent and under what conditions a person can or cannot consent.

- Brainstorm with the client what the client might say if he/she think a potential partner may be interested as well as how he/she can use active listening skills to ensure consent.
- Roleplay ways to ensure consent, perhaps using nonsexual themes for skill development.
- Discuss how to ensure safety in risky situations.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Ask the client to observe interactions in daily life or in music or the media and evaluate them using the CERTS model.
- If the client is in a relationship, ask him/her to practice skills learned with his partner and discuss how they used CERTS next week. Similarly, if the client becomes interested in someone, suggest practicing these skills and reporting back next week.
- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**
- Ask client to outline a plan for ensuring safety in risky circumstances.

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
  - What were some things you liked about today's session? What didn't you like?
  - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
  - How has our time today together been helpful?

- Is there anything else that we didn't get to that you think would have been helpful?

- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

MODULE 9

Accountability: Making Amends and Making a Difference

Accountability: Making Amends and Making a Difference

SESSION 1: **ACCOUNTABILITY AND RESPONSIBILITY**

Session Objectives

- Develop an understanding of what accountability is, how people can be accountable, and how it is important to not only be accountable and take responsibility for one's own behavior, but to care about one's community and to try to prevent harm to others.

Session Goals

- Help the client understand what accountability and responsibility are and start thinking about how they can take positive action.

Principal Contributor: Becker

→ Check In (5-10 min):

- Briefly check in about the client's week.
- Ask about questions, comments, thoughts regarding the last session/assessment.
- Review previous week's Out-of-Session Assignments (OSAs).

→ Suggested Session Content:

- Establish definitions of accountability and responsibility.
- Identify instances of accountability and responsibility in people's lives (e.g., family, friends, others and self).
- Identify instances of irresponsible behaviors and an absence of accountability.
- Explore thoughts, feelings, and behaviors that contribute to responsible and accountable behaviors versus irresponsible behavior and an absence of accountability. Have the client link these observations to him/herself.

→ Possible Activities:

- Brainstorm with the client definitions of accountable and responsible behavior.
- Inquire as to how the client has acted in responsible and accountable behaviors historically, and encourage the client to articulate ways in his/her life that he/she have shown accountable and responsible behavior more recently as well (e.g., participating in therapy).
- Have the client articulate ways in which his/her behavior was other than responsible/accountable (e.g., the behavior(s) that led to the referral to treatment).
- Have the client identify thoughts, feelings, or behaviors which led to irresponsible or unaccountable behavior (e.g., the behavior(s) that led to the referral to treatment).

- Help the client identify in retrospect how he/she could have demonstrated more responsible behavior and how he/she can do so in the present and future.

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Have the client keep a daily diary or log of ways in which his/her behavior during the week was responsible. Ask the client to note any urges and thoughts about engage in impulsive behavior or actual irresponsible behavior. What were the situations and behaviors? What thoughts and feelings contributed to his/her behavioral choices?

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions or similar ones:
    - What did you think about today's session?
    - What stands out? How might it be helpful in your life?
    - Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

SESSION 2: **MAKING AMENDS AND MAKING A DIFFERENCE**

Session Goals

- Clarify current understanding and feelings regarding the various effects of sexual misconduct.
- Learn how to make amends for one's behavior.

Session Objectives

- Review and reinforce client's cognitive understanding and empathetic appreciation of the harmful effects of sexual misconduct.
- Help the client identify ways to make amends for his/her misconduct.

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session/assessment.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content:

- **Distinguish between sympathy and empathy.**
- **Explore client's capacity to empathize with others in multiple situations and, drawing on Module 6, especially pertaining to sexual misconduct.**

→ Possible Activities:

- Discuss the difference between sympathy and empathy. Inquire as to what empathy feels like and what sympathy feels like. Ask whether the client has been the target of mistreatment, for example a victim of bullying or harassment and, if she/he would be willing to share how that felt.

- Ask that the client think about what he/she learned in Module 6 and the companion videos or treatment assignments and discuss what might it feel like to experience sexual misconduct in college and what might be useful to prevent or ameliorate such experiences.

- Discuss how people make amends for wrongdoing. How do people express regret and attempt to make things better?

- Explore with the client how she/he might make amends for his/her behavior. Let the client brainstorm ideas. Encourage a philosophy of giving back to the community in general, possibly making donations to victim organizations, making some type of amends to the victim/survivor (if and only if this is something the victim/survivor wants- as verified by the Student Conduct Office) and letting survivor know that she/he was NOT responsible for the misconduct. Note, because future criminal or civil proceedings may be possible, it is important that clients not be required to incriminate themselves in any way that could be used against them in later legal proceedings.

- Brainstorm with the client ways she/he may be able to make a difference in his/her community and prevent sexual misconduct. Possibilities include: intervening to stop someone from engaging in sexual activity with a person who appears incapacitated, not joking about sexual misconduct, intervening when you feel that a peer may be contemplating engaging in non-consenting behavior. Perhaps, encourage the client to come up with as many ideas as possible while you do the same and then compare lists and role play what might be said and done.

- Discuss with the client the men who intervened in the Stanford rape case of an intoxicated woman. Why might they have intervened? What might have happened if they did not get involved? How did they make a difference?

- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix F.

→ Possible Out-of-Session Assignments (OSAs):

- Have the client develop a list of ways that she/he may realistically make amends for his/her sexual misconduct. (Such activities could include bystander engagement, mentoring other students who may be engaging in risky behavior or sexual misconduct, calling 911 if needed.) If the victim/survivor requests an apology (Confirmed by the Student Conduct Office), one providing a genuine expression of regret for harm done can be developed and reviewed in session but should be reviewed with an attorney for the client to protect the client from risking self-incrimination which could influence subsequent legal actions).

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix F for the client to review and log written reactions for discussion next week. **Note: STARRSA videos should only be used in session.**

Clinician Note

It is common practice in sex offense specific treatment with adjudicated clients to have them write a letter of apology to their victim/survivor. Depending on circumstances, the letter may not be sent to the victim/survivor and only be used for treatment purposes. As noted previously, clients should not be put in a position where they are required by clinicians to incriminate themselves when future criminal or civil proceedings may occur. Therefore, alternative assignments that do not require specific admissions of wrongdoing often are best.

→ Check Out (5-10 min):

- Ask the client to answer one or more of the following questions:
  - What were some things you liked about today's session? What didn't you like?
  - Name something new that you learned today or that stands out and how it may be helpful to you in your life.
  - Is there anything else that we didn't get to that you think would have been helpful?

- Introduce next week's topic.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

Clinician Note

It is recommended that prior to the first session of the next and final module (Module 10), the clinician review records related to the client's referral, treatment, assignments, and notes, etc. The purpose of this process is discussed at the start of Module 10.

MODULE 10

Wrapping Up & Going Forward

Wrapping up & Going Forward

Clinician Note:

Prior to the first session of this module, it is recommended that the clinician review records related to the client's referral, treatment records, assignments and notes, etc. The purpose of this process includes:

- Assisting the clinician in assessing the client's progress and completing the final Risk–Needs-Inventory (RNI) and developing a treatment summary. This assessment process allows the clinician to identify any areas that may need to be addressed further, or for which additional support may be necessary. If time permits, and if clinically appropriate, these areas may be targeted in these last sessions. If, however, these areas cannot be fully addressed in the remaining sessions and are risk relevant, additional sessions may be warranted, and these needs should be documented in the discharge summary and, with the client's consent, appropriate recommendations and referrals should be made.

(Note: Clinician should not release any information to the referring college or university other than that the client has completed treatment. A release is required.)

- This final assessment process also allows the clinician and client to systematically create a list of the relevant areas and topics that were discussed during treatment and recognize the changes the client has made, as well as any remaining areas of challenge, if present. The clinician may complete the final RNI either prior to or during the first session of this last Module, by rating items independently, possibly with the client also rating him/herself during the session, or by rating the client conjointly with the client during the session, with the clinician's judgment being reflected in the final rating. Either way, results of the RNI are reviewed with the client. This exercise provides another way for the clinician and client to review, assess, and evaluate the course of treatment, the gains that have been made and note any risk relevant treatment needs, if indicated, protective factors, and safety strategies.

- Through this assessment process, the clinician can evaluate whether the client has successfully learned treatment concepts, is able to readily implement strategies that are contrary to sexual misconduct, and is likely to employ these strategies in different contexts in the future. If the client has significant deficits in any risk relevant areas, or presents a low likelihood of being able to successfully implement effective risk management strategies, the clinician may discuss the possibility of additional services with the client and will review the client's strategies for engaging in additional services, or requesting help and support for services that may be needed in the future.

If at the last assessment, the clinician has substantial concerns related to the client's progress and believes the client has continued treatment needs that may interfere with a successful return to campus, the clinician must discuss this issue with the client, provide recommendations, and possibly referrals for additional or specialized treatment. Clinical concerns may include the client's level of insight, understanding of factors that contribute to sexual misconduct, the extent to which the client has truly integrated information learned at an affective level, and whether the client has really changed in ways that would be inconsistent with future sexual misconduct. As discussed in the first session as part of informed consent, and is documented in the written informed consent document, the student's school will be informed that treatment has not been successfully completed, if this is so. This finding also will be noted in a written treatment summary report, for the clinician's records. If the client withdraws consent to allow the clinician provide a simple yes or no about treatment completion to their college or university, they must understand that this may impact his/her status. He/she should discuss this with their college and university. It is important that students also realize that although consent can be withdrawn for future disclosure, this does not impact disclosures that have already occurred. The clinician must inform the client that no reports indicating the client successfully completed treatment will be provided.

SESSION 1: **WHAT HAVE I LEARNED? ASSESSMENT & FEEDBACK**

Session Goals

- Review the course of treatment with the client; provide feedback.
- Obtain the client's opinions and views about treatment and his/her progress.
- Conduct discharge assessment using the RNI.
- Reinforce treatment gains and positive client changes.

Session Objectives

- Review the course of treatment with the client; recap important milestones, obstacles, and challenges and if and how they were overcome.
- Obtain the client's assessment of his/her treatment progress, including the client's perceptions of his/her areas of strengths and any areas of weaknesses, challenges and improvements, understanding of any current risks or needs, if present, as well as protective factors and supports.
- Review and reinforce client's strengths, newly developed skills, treatment gains, and positive changes.
- Use the RNI to review the client's current risk and protective factors, and identify any additional or outstanding treatment needs, if present.
- Assess the client's level of insight, appreciation of the wrongfulness of prior sexual misconduct, and sincerity regarding positive behavior change.
- Assess discrepancies between the client's perceptions of treatment, treatment gains, current risk and protective factors, and future plans, and those perceived by the clinician.
- Discuss any potential campus reintegration concerns (if the client has been suspended from campus), and client's receptivity to additional services/

Session Objectives... continued

resources, if needed.

- Consider if additional services are needed, and client's receptivity to such.
- Provide and received comprehensive feedback about treatment.
- Gather relevant information for the Treatment Summary Report

→ Check In (5-10 min):

- **Briefly check in about the client's week.**
- **Ask about questions, comments, thoughts regarding the last session.**
- **Review previous week's Out-of-Session Assignments (OSAs).**

→ Suggested Session Content and Activities:

- **In this session, the clinician formally transitions to discharging the client from treatment. Begin with a recap and review of the entire treatment process.**
- **Introduce this as the last module and treatment wrap up.**
- **Discuss with the client what she/he feels has been achieved in treatment. Encourage the client to take the lead. Listen and explore the following areas that can help confirm that treatment goals have been achieved, and are being maintained and incorporated into a realistic prosocial life plan.**
    - Client understands relationships between thoughts, feelings, and behaviors, particularly as they pertain to their sexual misconduct, risky situations, and behaviors.
        - Client possesses a realistic plan for emotional and behavioral regulation strategies, and a clear sense of which strategies are best suited to which circumstances.

- Client successfully identifies any unhealthy feelings, attitudes, and behaviors, and understands the interaction between these factors, as well as factors that help to reduce or intensify/ increase these factors.
- Client possesses realistic strategies (i.e., are likely to be implemented) to avoid risky situations, exit risky situations, and increase positive, prosocial activities and relationships.
- Client has developed (or strengthened) a prosocial, responsible approach to relationships and life.
- Client successfully recognizes situations where s/he may need additional help.
- Client knows where to obtain help and how to engage in services.

- Follow-up questions may include: What new skills and strategies have you developed throughout the course of this treatment? How may they be useful?
- What changes have you made or noticed in yourself (e.g., attitudes, feelings, behaviors, etc.).
- What, if any, are areas that you feel might be useful to continue to work on going forward? (Explore willingness for additional therapy, possible supports on campus or in the community, etc., if indicated)

- **Review or complete the RNI with the client (If there are significant differences between clinician's assessment of the client's progress, the client's perceptions and successful treatment completion; discuss these discrepancies with the client.) .**

- **If deemed necessary/appropriate, the clinician should discuss whether the client's is open to additional treatment or supportive services on campus or in the community.**

→ Possible Out-of-Session Assignments (OSAs):

- **Instruct the client to reflect on today's session and write down any additional thoughts and/or reactions.**

- **Encourage the client to write a report describing their course of treatment and progress.**

- **If the client has been suspended, ask the client to identify any challenges/concerns about returning to campus.**

- **Ask the client to develop a personalized plan for his or her life, at least for the foreseeable future (See template: My Plan for Success in Appendix F).**

→ Check Out (5-10 min):

- **Ask the client to answer the following or any similar questions:**
    - Is there anything that we did not cover today that you want to be sure we discuss at the next session?

- **Introduce next week's topic.**

→ Supplies/Handouts:

- **Computer, paper and writing implement, or white board and markers for written activities.**

- **RNI Manual and RNI Face Sheet**

SESSION 2: **PLANS FOR HEALTHY LIVING: GOING FORWARD**

Session Goals

- Continue from the last session to review and recap course of treatment, provide feedback.
- Continue to provide positive reinforcement about treatment gains.
- Discuss clinician's final Treatment Summary Report (see Appendix E for sample).
- Review client's plans for going forward.
- Discuss any additional treatment services and needed referrals, if indicated.

Session Objectives

- Finish review of treatment progress and any further treatment needs.
- Discuss the client's plans for going forward and steps for achieving these goals.
- If the client was suspended, review reintegration plans and strategies, including additional services or supportive service requirements (at the end of the session, client should have a clear sense of reintegration plans, any additional services/resources that s/he may engage in upon return, if indicated. If the client is not engaging in additional or supportive services, the client should know how to seek out and engage in such services in the community or at campus).
- Wrap up on a positive note as possible with encouragement and hope for further progress.

→ Check In (5-10 min):

- Ask about the client's thoughts, feelings, and/or questions and concerns regarding the last session/assessment.

→ Suggested Session Content and Activities:

- Begin with reviewing last week's session and any items that were not completed from last week. These may include:
    - Additional feedback and opinions from the client about his/her treatment progress.
    - Reviewing treatment gains and the client's plans for going forward.
    - Asking the client their opinions about treatment – what worked, what was helpful, what they liked/disliked, and what they think might be more helpful for other student/clients in the future.
- Provide appropriate supportive reinforcement of client's ability to make healthy decisions and engage in a life consistent with their goals and values.
- Provide supportive reinforcement for client's ability to problem-solve, including how to obtain help should they need it going forward.
- Obtain specific feedback about the client's treatment experience.

→ Check Out (5-10 min):

- Wrap up treatment by acknowledging the hard work completed, reinforcing positive gains made and wishing the client well in the future.

→ Supplies/Handouts:

- Computer, paper and writing implement, or white board and markers for written activities.

APPENDIX A

STARRSA Training Program Slides

STARRSA Program Training Slides

- Cognitive Behavioral Therapy Treatment Program
- Active Psychoeducational Program

STARRSA | Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking (2014-AW-BX-K002)

*Please review the "Getting Started" slide prior to implementation.

*Please see the supplemental training video on the STARRSA flash drive

*For in-person trainings, please contact Raina Lamade, Ph.D. lamade@fdu.edu or rainalamade@hotmail.com (631) 748-7687 or Robert Prentky, Ph.D. rprentky@fdu.edu

Presentation Structure

Section I: Project Overview
- Project Overview
  - Goals, Structure, Personnel, Design

Section II: Background Information
- The "Problem"
- College Campuses
  - 7 converging risk factors
- College Students
- Lessons learned from Universities
  - Needs
- Risk and Treatment
  - Convergence of multiple areas
  - Treatment outcome studies
- Core Framework of this model: RNR

Section III: Product Overview
- Program Modules
- Feedback

Section IV
- The Contributing Factors Checklist

Section V
- The STARRS Cognitive Behavioral Treatment Program
- The Risk Needs Inventory (RNI)

Section VI
- The STARRSA Active Psychoeducational Program
- The Risk Needs Screen – Test Version (RNS-TV)

Section VII: Getting Started
- Contacts, support and assistance

SECTION I

Project

Grantor: Department of Justice, *Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking* (SMART Office)
- 4 year grant awarded & received October, 2014 (Summer, 2018)
- Considers the nature and scope of problem and gap in area of service (i.e., treatment to target the behaviors associated with sexual offending for students responsible of sexual misconduct).
  - Primary Prevention Programs

Initial Goals:
- Create and pilot an empirically based treatment program as a sanction for students found responsible for sexual misconduct
- Gather, analyze, and report all feedback data related to the *implementation* of the treatment program

Six Principle Goals

(1a) identifying the risk factors and treatment needs that distinguish students with a greater likelihood of committing sexual assault by surveying a diverse sample of 1,000+ male undergraduates.

(1b) surveying a sample of 1,000+ female undergraduates regarding campus climate, perceptions of risk, and reasons for not reporting *unwanted sexual behavior*

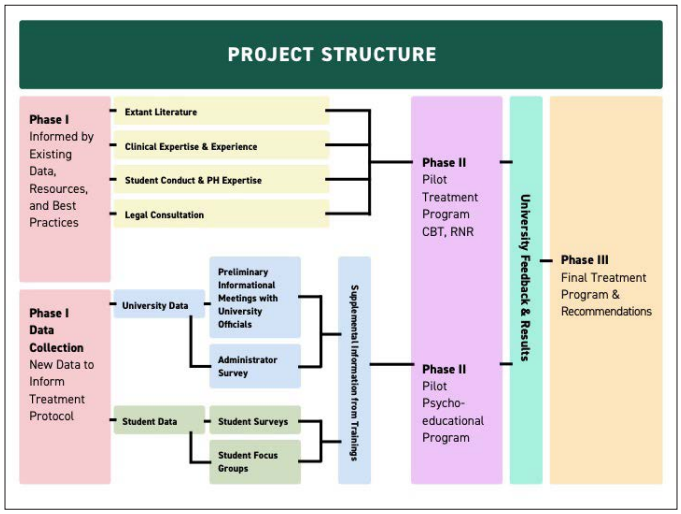
(2) using the results of the male surveys and the empirical literature to design a risk and needs assessment protocol and an evidence-based treatment curriculum;

(3) educating student conduct professionals (e.g., Title IX Coordinator, conflict resolution officers, judicial panel members) to use these tools to individualize therapeutic sanctions;

(4) training clinicians to administer the treatment curriculum with fidelity to intervention modality and dosage recommendations in accordance with RNR principles;

(5) pilot-testing the model within the judicial sanction process at diverse educational institutions guided by direct consultation;

(6) evaluating the implementation through a structured debriefing after 12 months.



Project Structure: Phase I

Phase I: Survey Students and Institutions

Male students:
- INTENT: To identify the risk factors and treatment needs that distinguish students with a greater likelihood of committing sexual assault
  - 12 institutions and 1,167 students responded
  - 17 unique domains included in the survey

Female Students:
- INTENT: To obtain information regarding campus climate, perceptions of risk, reasons for not reporting *unwanted sexual behavior,* and perspectives about their decisions to report or not report
  - 12 institutions and 1,399 students responded
  - 10 unique domains included in the survey

Focus Groups:
- INTENT: To obtain opinions directly from the population being served about treatment options and perceived barriers to treatment.

Survey of Campus Staff:
- INTENT: To obtain information about policies, needs, and barriers of treatment intervention sanctions

Phase I: Data from Multiple Areas & Sources

To develop this program, we considered the following areas, methods and sources to create a comprehensive program that may be implemented with all students.

- Extant Literature
  - Adults who commit sexual offenses
  - Juveniles who commit sexual offenses
- College student population literature
  - Sexual misconduct on campus
- Project surveys and data gathering
  - Students
  - Stake holders/staff
- Expertise
  - Clinical
  - Risk assessment
  - Public Health
  - Student conduct
  - Legal

Project Structure: Phase II

Phase II : Development and Implementation

- Design a risk and needs assessment protocol
- Design an evidence-based treatment curriculum
  - Developed Contributing Factors Checklist
  - Developed RNI-TV
- Campus Recruitment
  - Developed psychoeducational variation of the treatment program
- On-site Training to administer the Program with fidelity
  - Feedback about logistics and implementation to incorporate into final pilot manuals
- Pilot-test the STARRSA program over two semesters
- Evaluate the implementation through regular online surveys and structured debriefings

Project Design

- NOT human subjects research
  - No information that identifies or could be used to identify a student (e.g., name, student ID, etc.) will be collected by the project
  - Pilot sites are prohibited from sharing such information with Project personnel and others outside the project
    - Privacy Certificate and Confidentiality Agreement
- The project is exclusively interested in your feedback about the program and the products

SECTION II

The "Problem"

The Magnitude & Nature of the Problem: Long Known* and Well Understood

*** dating back to Kanin's papers in the 1950s**

College Campuses:

presenting risk factors constitutes something of a "Perfect Storm" for sexual misconduct

7 Risk Converging Factors

(1) ***college students / social culture*** - an abundance of very young adults at the height of sexual exploration who are drawn to a **social culture** that promotes, and indeed places emphasis on informal, casual "dating" (e.g., "hooking-up," "friends with benefits"), including those few (most often young men) who are rape-prone;

(1 continued) ***a social culture*** **-** Abbey (1991) noted that, "More than 80% of the rapes that occur on college campuses are committed by someone with whom the victim is acquainted; approximately 50% are committed on dates," (p. 165);

(2) ***victim access*** - in addition to partying, there are numerous opportunities for easy access to potential victims; many of these opportunities facilitate socializing – from meeting in classes to sports, residence halls, clubs, social gatherings, just walking across campus;

(3) ***alcohol / drugs*** *are ubiquitous* - as part of the "social culture," alcohol is ever-present and readily available to facilitate disinhibition, along with readily available "rape drugs" that produce anterograde amnesia, such as the benzodiazepine Rohypnol and the CNS depressant GHB (gamma-hydroxybutrate);

(4) ***developmental immaturity of the respondents*** - the young men, typically, in the age range of 18 to 21, are themselves still in ***adolescence***, with the same psychosocial, psychosexual, cognitive, and neuro-cognitive immaturity of juveniles, with all of the predictable sequelae of risk taking, impulsivity, poor decision-making, increased proneness to disregarding or breaking the law, and intense, often poorly-managed emotions;

(5) ***coercion-supporting peer groups*** - these groups are more likely to espouse and condone rape-supportive attitudes, minimization & trivialization of sexual assault, sexual entitlement and the game of "scoring," and attitudes characterized by hostile and negative masculinity;

Note: there is an over-representation of male athletes and fraternity members among those alleged to have committed sexual assaults

(6) ***Victim Pool*** - victims can be naïve and trusting; student perpetrators do not raise instinctive red flags of *danger*; they are just *out for a good time* (which most are); victims often are away from home for the first time and looking to have a good time themselves

(7) ***Immunity*** - perceived sense of immunity; campus is a protected environment; rarely does anyone get in trouble; since everyone is doing "it" (partying) it can't be wrong or risky.

College Students

"emerging adults"

- **Closer to adolescents than to adults maturationally & developmentally**

Key Characteristics

- **For all adolescents and (most) college students:**
  - Emotions are experienced with greater intensity
  - Developing social & interpersonal skills
  - Attitudes & beliefs are evolving
  - Abstract thinking and reasoning are developing
  - Problem-solving & judgment tends to be poor
  - Shorter attention spans
  - Impulsivity & risk-taking are common
  - Self-focus & narcissism are "normal"
  - More dependent on their social environment and far more subject to peer pressure

Hallmarks of "Normal" Adolescent Development

- RISK-TAKING
  - risk-adversity increases with age; the hedonic motive in adolescence overshadows rational recognition of adverse outcomes
    - Steinberg (2004): "increased risk taking in adolescence is normative, biologically-driven, and inevitable." [cf., Levin & Hart, 2003; Reyna, 1996; Reyna & Farley, 2006; Rice, 1995]
- EMOTIONAL INTENSITY & LABILITY
  - associated with changes in reproductive and stress hormones
- IMPULSIVITY
  - associated with CNS immaturity - frontal lobe continues to mature into the mid-20s
    - Dahl & Spear (2004)

Key Take-Aways

- With this population, we would be remiss if we did not emphasize their malleability and receptivity to change.
- Although emerging adults are moldable, they also have a harder time fully appreciating consequences, understanding cause and effect, controlling impulses, and making sound decisions.
- It is a prime time to intervene because we are more likely to make a lasting influence.

Outreach to University Administrators

Lessons Learned from Institutions

- **The Behaviors Vary**
  - There is a broad spectrum of sexual and gender-based misconduct being managed
- **The Students Vary**
  - Heterosexual males are principal offenders, but females and members of the LGBTQ community offend as well
  - The client population presents unique demand
    - Differentiating students based on risk, protective factors, and intervention needs is critical
    - Client considerations – neurocognitive and psychosocial immaturity, emerging adulthood
    - Responsivity to sanctioned treatment, amenability, hostility, "avoidance" (leaving campus & going elsewhere)
    - Two clients: – students and university
- **The Processes Vary**
  - Although regulated by the same law and guidance, institutions have unique ways of addressing, managing, and resolving reports
  - Institutions employ a wide-range of sanctions, but most often resort to no-contact orders, educational interventions, probation, suspension, or expulsion.

Lessons Learned from Institutions

- **The Environment is Complex**
  - Nature of the behavior and consequent high profile "environment" for campuses
  - Complex parameters – must comply with multiple laws, regulations, policies, procedures, and guidance documents, e.g. Title IX / Clery / FERPA / HIPAA, Dear Colleague Letters, lawsuits
- **Institutional Needs and Desires Vary**
  - Some institutions want to provide treatment on campus, others want to provide it off campus, some want both
    - Note possible physical/emotional safety concerns if interventions are provided to those who perpetrated in the same physical/temporal space as those who have been victimized
  - Some institutions can mandate treatment, others can only recommend it
  - Some institutions want to provide interventions for students *not* found responsible for sexual misconduct but whose behavior is concerning
  - Some institutions expressed a desire for psychoeducation services delivered by facilitators other than mental health professionals

Some Take-Aways

- Approach has been largely process and prevention focused and victim centered.
  - Victims must be at the center, but by exclusively focusing on victims we are not adequately addressing the problem, only those who are directly harmed.
  - Prevention of course should be a component, but we need intervention too. Because one of the goals of this program is to reduce future reoccurrence of sexual misconduct, this program is an intervention but also a secondary/tertiary prevention.
- Treatment is very rarely an option and there has been little to no emphasis on post-adjudicatory interventions that reduce the risk of re-offense

What We Know About Risk & Treatment

State / federal legislation / funding drives research

- **college students are invariably <u>not</u> adjudicated;**
- **The empirical literature on treatment and risk is based on adjudicated juvenile & adult sex offenders**

- There is a very substantial group of literature on college students that engage in sexual misconduct, extending over 65 years, it has focused on "traits" (e.g., "cognitive distortions" - rape myth beliefs, attitudes associated with hostile masculinity, narcissism, sexual entitlement) & correlative factors (e.g., alcohol, peer pressure)

- Although this is a very rich group of literature, it has not informed, nor has it been informed by, an entirely separate research literature on adjudicated juvenile and adult sex offenders. This latter literature was driven almost entirely by the needs of laws designed to manage sex offenders, with two foci in particular – risk assessment and treatment.

Psychotherapy: Overall Effectiveness

- "Significant and large effects of psychotherapy (Chorpita et al., 2011; Smith, Glass, & Miller, 1980; Wampold, 2001)"
- "Constant across most diagnostic conditions"
- "A variety of psychotherapies are effective with children, adults, and older adults."
- "The results of psychotherapy tend to last longer and be less likely to require additional treatment courses than psychopharmacological treatments."

American Psychological Association:
http://www.apa.org/about/policy/resolution-psychotherapy.aspx

Treatment Outcome Studies

Treatment Outcome Studies with Adjudicated Sex Offenders

Adults

Treatment Outcome Studies

Adjudicated Adults who committed sexual offenses

Study	Country	SRR: Tx / No Tx
Schmuker & Losel, 2015*	multi	10.1%/13.7%
Greenberg et al., 2002	Australia	R: 7% / 4.5%
Marques et al., 2005	U.S.	22% / 19%-20%
Zgoba & Simon, 2005	U.S.	R: 15% / 19.4%
Nicholaichuk et al., 2000	Canada	14.5% / 33.2%
Hanson et al., 2002**	multi	12.3% / 16.8%
Hanson et al., 2009***	multi	10.9%/19.2% (A&J)
Hall, 1995****	multi	19% / 27%

Except for two with "R" in front, all other studies combine child molesters with rapists. SRR = Sexual recidivism rate. TX= treatment

*** meta-analysis: 29 studies n = 10,387, **meta-analyses: 43 studies, n = 9,454; *** meta-analysis: 22 studies, n=6746 **** 12 studies, n = 1,313**

Collaborative Outcome Data Project

(Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002)

- Meta-analysis of 43 studies (n= 9,454);
- averaged across all studies, SSR was 12.3% for TX & 16.8% for no-TX (comparison) groups;
- among "modern" TX studies, the TE (Treatment effect) increased from 4.5% to 7.5%

Juveniles
Better analogue for college students

1. Much closer in age, hence much closer developmentally
2. Much better approximation of base rates for theoretical risk of repeat

Sexual re-offense base rates for juvenile sex offenders: LOW BASE RATE

15 Studies: below 10%
10 Studies: 10% - <15%
5 Studies: > 15%

Sexual re-offense base rates for juvenile sex offenders:

15 Studies: below 10%

Kahn & Chambers, 1988	9.0%
Kahn & Chambers, 1991	7.5%
Lab, Shields, & Schondel, 1993	3.7%
Brannon & Troyer, 1995	3%
Hagan & Cho, 1996	9%
Sipe, Jensen, & Everett, 1998	9.7%
Auslander, 1998	8.1%
Rasmussen, 1999	7.6%
Alexander, 1999	7.15
Prentky, Harris, Frizzell, & Righthand, 2000	4.2%
Waite et al., 2005	4.3%
Miner, 2002	8.1%
Parks & Bard, 2006	6.4%
Vandiver, 2006	4.3%
Kemper & Kistner, 2007	3.4%
Caldwell, 2007	6.8%

10 Studies: 10% - <15%

Smith & Monastersky, 1986	14.3%
Becker, 1990	10%
Schram & Milloy, 1991	10.2%
Bremer, 1992	11.0%
Boyd, 1994	11.0%
Worling & Curwen, 2000	12.8%
Hecker, Scoular, Righthand & Nangle, 2002	11.0%
Martinez, Rosenfeld & Flores, 2004	14.3%
Epperson & Ralston, 2005	13.2%
Reitzel & Carbonell, 2006	12.5%

5 Studies: > 15%

Borduin et al., 1990 (N = 16)	44%
Rubenstein et al., 1993 (N = 19)	37%
Langstrom & Grann, 2000	20%
Nisbet, Wilson, & Smallbone, 2004	25%
Borduin et al., 1990 (N = 16)	38%

30 JSO Re-offense studies

- **52% below 10%**
- **84% below 15% [26 / 31]**
- If 15% is the estimated BR, and we attempt to assess risk without "betting" the BR, our "accuracy" must hit 85% or better

Treatment Outcome Studies

Juveniles who committed sexual assault/misconduct

Study	Country	SRR: Tx / No Tx
Reitzel & Carbonell, 2006*	multi	7.37%/18.93%
Worling et al., 2010	Canada	9% / 21% 20 year follow up

*** meta-analysis: 9 studies n = 2986**

Summary of Treatment Studies

- Low recidivism, especially for juveniles.
- Specialized treatment for individuals who engage in sexual assault/misconduct show the greatest effect: reduction of recidivism.
- Programs that adhere to an RNR framework show the greatest effect (Hanson et al., 2009).
- No differences in voluntary and non-voluntary (mandated) treatment, although change in motivation as a process and the use of MI/ME techniques were helpful (Schmucker & Losel, 2015).
- Interventions that meaningfully engage higher risk offenders in the process of changing their criminogenic needs have better outcomes (Hanson, et al., 2009).
- Among "modern" TX studies, the TE (Treatment effect) increased from 4.5% to 7.5% (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002
- **For juveniles**:
  - importance of developmental changes and therefore multiple assessment points
  - consideration of strengths into treatment planning
  - the role of informed consent, including an explicit discussion about the limits of confidentiality (Worling & Langton, 2012).
  - CBT effective in decreasing recidivism (Fanniff & Becker, 2006).

Core Framework of this Program: Risk-Needs-Responsivity

- **"RNR"**

Hanson, Bourgon, Helmus, & Hodgson (2009)

- The Principles of Effective Correctional Treatment also apply to sexual offenders: A Meta-Analysis;
- Based on a meta-analysis of 23 outcome studies, the sexual and general recidivism rates for treated sex offenders were lower than the rates observed for the comparison groups (10.9% vs. 19.2% for sexual recidivism.
- *"Programs that adhered to the RNR principles showed the largest reductions in sexual and general recidivism. Given the consistency of the current findings with the general offender literature, the authors believe that the RNR principles should be a major consideration in the design and implementation of treatment programs for sexual offenders."*

Applicable Model

- RNR does not fit a traditional Medical Model that is based on psychopathology
- RNR is defined more as a Psychosocial Model or Social Learning Model in which psychosocial interventions target risk

(Andrews, Bonta, and Hoge 1990; Andrews, Zinger, Hoge, Bonta, Gendreau, and Cullen 1990; Gendreau 1996; Andrews 2001; McGuire 2004)

Andrews & Bonta, 1994, 2006

According to Andrews & Bonta:

the accurate and objective assessment of risk, needs and responsivity is one of the most important features of an effective correctional treatment system

The empirical evidence appears to support such a conclusion.

A: Risk Principle

- How much risk can we tolerate?
- Under what circumstances?
- Who gets treatment?
- How much treatment?

2 Major Components to Risk

1. Existence of a potentially harmful agent (e.g., people, diseases, toxins, situations, etc.)
2. Likelihood that the hazards associated with the agent in question will occur

Examples:

- Agent: Nuclear Power Plant
  - Hazards: meltdown (Chernobyl disaster in 1986), terrorism, etc.
- Agent: Predisposition to Heart Disease
  - Hazards: morbid obesity, cigarette smoking, high cholesterol, sedentary lifestyle
- Agent: Student Offender
  - Hazards: person-specific internal factors and external events, situations, circumstances (RNI –TV components)

Risk Guides Selection of "Clients"

- Risk principle determines how much treatment (or psychoeducation) should be provided based on level of risk
- Low Risk: "If it ain't broke, don't fix it"
  - (Andrews & Dowden, 2006) – asking Low Risk offenders to be in treatment will NOT improve outcomes, according to Andrews & Dowden

Risk Principle: 2 Parts

1. Assessment of Risk
2. Matching treatment intensity to risk level

Assessment of Risk

- Use of traditional unstructured clinical or professional judgment yields predictions that are no better than chance
- Risk Factors – based on scientific evidence demonstrating a strong relationship between the factor and recidivism

Risk Factors

- Static
- Dynamic:
  - Acute
  - Stable
- Protective

All Risk Factors have the same purpose:

- Determining the potential (i.e., likelihood, probability) for harmful behavior toward self or others

Risk & Treatment

- Risk is understood to be associated with the effect of treatment:
  highest risk offenders benefitting the most
  and lowest risk offenders benefitting least
- But ONLY when treatment is delivered according to the NEEDS & RESPONSIVITY principles

B: Needs Principle

- Need Principle refers to "Criminogenic" needs, NOT psychological needs
- Criminogenic needs are understood to be needs that are:
  1. directly related to offending behavior
  2. are changeable
  3. when changed, lower risk of behavior

- Targeting psychological / clinical needs unrelated to offending behavior is a powerful tendency for most clinicians based on their training and what makes "intuitive" sense
- but will NOT reduce risk of offending behavior (Andrews et al., 1990; Andrews & Bonta, 2006)

Criminogenic = Dynamic
(A= acute; S= stable)

- Depression (A)
- Anxiety (A)
- Anger (A)
- Drunkenness (A)
- Criminogenic Attitudes (S)
- Bad / Criminal Peers (S)
- Intimacy Deficits (S)
- Social Skills Deficits (S)

- Targeting criminogenic needs does NOT mean use of the same interventions with all offenders
- Interventions MUST be individualized
  i.e., tailored to the individual

C: General Responsivity

- Match between treatment modality and offender's learning style
- Maximizing receptivity / openness
- Internal Responsivity
  - Matching content and pace of treatment sessions to specific attributes of offenders, such as personality traits and cognitive maturity
- External Responsivity
  - Setting; characteristics of treatment providers

RNR Based Treatment Outcome

Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). *A Meta-Analysis of the Effectiveness of Treatment for Sex Offenders: Risk, Need, and Responsivity*. Ottawa, ON: Public Safety Canada.

SECTION III

Product Overview

- Developed by a team of experts in clinical, forensic, and risk assessment with decades of experience assessing and treating juvenile and adult sexual offenders; experts in student conduct matters; public health scholars; lawyers; researchers; practitioners
- Combined essential components of what we know empirically (based on the specific research for this population and sex offenders more broadly), clinical practice and experience with assessment and treatment, knowledge of the student conduct process and campus needs, and created a multifaceted treatment program
- Attended to various factors, including:
  - A unique population (emerging adults) and a unique problem (sexual misconduct) in a specific context (campus, college environment) that requires a highly targeted treatment
  - A post-millennial population that utilizes multimedia as part of everyday life
  - Diversity of students, institutions, and fact patterns

Two Programs

- STARRSA Cognitive Behavioral Therapy (treatment)
- STARRSA Active Psychoeducation (AP)

***Pilot materials were modified in response to feedback provided from pilot sites during trainings. Please review pilot materials and contact Raina or Elise if you have any questions.**

Product Overview

- Contributing Factors Checklist (CFC)
- STARRSA Modularized CBT Treatment Program
  - Risk-Needs Inventory (RNI-TV)
  - Resources: Videos, PP, Experiential Exercises
- STARRSA Modularized Active Psychoeducation Program
  - Curriculum structure
  - Learning check points
  - Resources: Videos, PP, Experiential Exercises
- Training, Consultation, and Support
  - Logistical

Modules

Module 1: Orientation, Assessment & Treatment Planning
Module 2: Sexual Behavior & Sexual Abuse
Module 3: Focus on Socialization & Sexualization in Society
Module 4: A Perfect Storm: Understanding & Resolving Risks for Sexual Abuse
Module 5: Negative to Healthy Masculinity
Module 6: *Consequences* of sexual abuse
Module 7: *Behavior is a Choice*: Choosing wisely
Module 8: Developing healthy relationships
Module 9: Accountability: Making amends and making a difference
Module 10: Wrapping up & Going forward

Psychotherapy & Psychoeducation

	Psychotherapy	Psychoeducation
Goals	-Treat psychological disorders and mental health problems -Personality change -Symptom relief, reduce symptoms/symptom episodes -Enhance quality of life -Promote adaptive functioning -Increase the likelihood of making healthy life choices -Increase knowledge, self awareness -Skills development/acquisition	-Increase knowledge -Enhance quality of life -Assist in impacting problems -Increase the likelihood of making healthy life choices -Skills development /acquisition
Focus	-Application of evidence based techniques, including educational techniques -Use of the therapeutic relationship -Past, present and future focused -Explores thoughts and feelings	-Application of educational techniques -Tends to be focused on remediating problems in the here and now (present) -Focuses on thoughts and attitudes
Method	Use of specific techniques within a principled framework	Didactics and planned curriculum
Delivery	Licensed mental health provider (psychologist, MHC, SW, psychiatrist)	No licensure requirements.
Obligations	Mandated reporter	Possible to Title IX office and other officials
Effectiveness/Efficacy	Strong support (APA Division 12) http://www.div12.org/psychological-treatments/treatments/	For specific outcomes
Cost	Varies, depending on insurance; dx may be required	Cost effective, particularly when administered in a group

Referrals to Programs

Factors to consider in determining appropriateness

- Use the CFC
  - Consider if it is knowledge/skills based deficit – refer to STARRSA Active Psychoeducation program
  - Consider flagged (noteworthy) items – if many, consider referring to STARRSA CBT treatment program
  - Consider number of items present
  - Consider severity of sexual misconduct – more severe misconduct may suggest the need for STARRSA treatment
- Prior known acts of sexual misconduct or aggression – multiple offenses, entrenched behaviors, consider STARRSA CBT treatment
- Consider individual and contextual factors
  - Is there a knowledge deficit? If y: STARRSA Possible referral for STARRSA Active Psychoeducation
  - Are there many protective factors? If y: Possible referral for STARRSA Active Psychoeducation
- Additional information
  - Presence of suicidal/violent ideation (passive and not acute = hospitalization) – once stabilized, not acutely SI/HI, refer to STARRSA CBT Treatment program
  - Suspect SMI - Serious Mental Illness (Major Depressive Disorder, Bipolar Disorder) – refer to STARRSA CBT Treatment Program
  - Suspect other co-morbid conditions
  - Longstanding behavioral problems (pattern of behavioral problems) – refer to STARRSA CBT Treatment Program
  - Emotional Dysregulation – consider referral to STARRSA CBT Treatment Program

SECTION IV

Contributing Factors Checklist

- **What It Is:**
  - Tool for institutional staff members charged with making sanctioning decisions
  - Organizing framework for thinking about relevant factors in a systematic way
  - Checklist of various factors frequently associated with engaging in sexual misconduct. Some describe the incident, others describe the student. Approximately half of the items are empirically supported as risk factors associated with sexual aggression.
  - Highlights factors that are of particular concern and should be considered in relation to sanctioning
- **What It's Not:**
  - A tool for determining whether sexual misconduct occurred
  - A tool for predicting level of risk. It is not validated to do so; there are no cutoff scores.
  - A tool that tells you what to do

Contributing Factors Checklist

- **How It's Used:**
  - Used following a finding of responsibility and prior to a sanctioning decision
  - Completed using information on-file; does *not* require an interview
  - Obtain information from verbal reports and from inquiry (hearing & investigation)
  - Ideally completed by two or more people to enhance accuracy and to resolve differences of opinion; contradictory scores should be reconciled through a meeting/discussion
  - Scored with:
    - Yes – clearly present
    - No – not present
    - ? – possibly present
    - Note: Seemingly contradictory information can be noted in the final written section
  - Intended to be included in the referral packet provided to the treating clinician after an appropriate FERPA release has been obtained
  - Technical assistance in scoring is available from the Project team

Contributing Factors Checklist

Six Sections:

1. Incident characteristics
2. Prior misconduct
3. Alcohol and peers
4. Impersonal behavior
5. Hostility
6. Protective factors

Not All Factors Are Equal

- We note that some items are of greater significance than others; they in **black**
- It should be evident that these highlighted items cause heightened concern
- The more concerning factors are, in varying degrees, associated with deceit, conning, manipulation, dissimulation (intentionally presenting oneself as something else; disguise or concealment of character/personality), premeditation, and significant anger control problems.

Contributing Factors Checklist

INCIDENT ONLY CHARACTERISTICS
Any non-consensual non-contact sexual conduct such as unwanted sexual remarks
Any verbal pressure to have sex stopping short of threatening physical harm
Verbal threats of physical harm directed at Complainant
Any non-consensual sexual touching
Any stalking of Complainant before or after incident
Any non-consensual oral, anal, vaginal penetration by the penis, fingers or objects
Were there multiple acts of penetration or more than one form of penetration within the same incident
Any non-consenting sexual acts involving multiple perpetrators
Any physical force, including use of body weight differences
Was the violence gratuitous [i.e., clearly exceeded what was minimally necessary to force sexual contact (i.e., commit the sexual misconduct)]
Did the violence level escalate (i.e., increase) , such as kicking, punching, or choking, *in response to resistance*
Any injury to Complainant such as bruises, abrasions or sprains
Was the incident report to local police (campus or community)
Did Complainant receive medical care
Was forensic evidence gathered via a "rape kit"

Contributing Factors Checklist

PRIOR MISCONDUCT
Any prior reports of academic misconduct
Any prior reports of physical aggression (e.g., fighting)
Any prior reports of non-consensual sexual kissing, touching, groping or other contact sexual misconduct
Any prior reports of using threats of harm or physical force, even minimal, to coerce nonconsensual, penetrative sexual acts
Any prior reports of non-academic conduct violations other than those mentioned above

ALCOHOL AND PEERS [BOTH]
Any pressure on Complainant to drink alcohol
Was complainant intentionally given a spiked drink(s) without Complainant's knowledge (e.g., evidence that respondent knowingly gave the Complainant a drink with drugs with the intent of facilitating sexual misconduct)
Any pressure on Complainant to consume drinks spiked with other drugs
Did incident take advantage of an already intoxicated, stoned, or otherwise incapacitated Complainant who was unable to consent (e.g., Respondent committed the sexual misconduct knowing that the Complainant was impaired from drugs or alcohol)
Was Complainant unconscious, passed out or asleep during all or some of the incident
Any signs of excessive routine use of alcohol by Respondent, as evidenced by the number of days per week Respondent ingests alcohol and/or indications of binge drinking (more than 5 drinks per occasion)

Contributing Factors Checklist

IMPERSONAL BEHAVIORS [BOTH]
Complainant was a stranger
Complainant was known or recognized and complainant did not have any prior consensual sexual activity with the respondent
Any involvement in recording pictures/videos of the incident
Any posting on Internet, or emailing/texting about the incident
Any remarks in which it seemed as if Respondent was conceited, bragging, boasting, or trying to impress the Complainant or other students/peers
Any remarks by Respondent to peers that suggested incident was viewed as a "sexual conquest"
Respondent evidences no concern for Complainant
Respondent known or suspected to associate with other students/friends/ housemates that promote sexual "conquest" (including residence in an apartment or house that was the setting of other complaints in the past)
Respondent did NOT use a condom
Respondent typically chooses sex partners based primarily on sexual availability, without emotional or other attraction as selection criteria.

Contributing Factors Checklist

HOSTILITY [BOTH]
Use of verbal coercion or pressure that was highly manipulative, e.g., implying that sex was "owed," or an "obligation" or "expected"
Any statements during or after that blamed the Complainant, such as "you like this," " you deserve this," or "you wanted this"
Any demeaning, degrading, or disparaging name-calling that was gender or sexual-orientation-focused, such as whore, bitch, cunt, twat, slut, queer, lezzie, dyke, fairy, fag/faggot
Any statements intended to demean or degrade the Complainant's race, ethnicity, religion or personal characteristics (such as being overweight)
Verbal threats of harm directed at Complainant
Respondent's responses reflected anger at Complainant and/or institution, or an affront or indignity towards them
POSSIBLE PROTECTIVE FACTORS
Respondent appears to accept responsibility for the incident
Respondent is currently involved in counseling/therapy
Respondent expresses willingness to be in therapy around current incident
Respondent has a moderate to strong academic record
Respondent appears to express some genuine degree of regret, remorse or contrition
Respondent appears to associate with healthy peers that do not actively promote sexual conquest

Contributing Factors Checklist

Summary section for:

- Salient behavioral and potentially risk relevant concerns
- Items that the reviewer wants to emphasize
- Features not captured in any of the items under the previous 6 areas
- Any unusual features of the case of sexual misconduct that might be relevant
- Protective factors
- Other relevant current or historic considerations

CFC Exercise

Exercise

- Read vignette
- Complete the CFC as a group
- Determine whether a referral to the CBT or AP program would be most appropriate

Vignette

David and Jessica

Vignette: David & Jessica

David and Jessica met at orientation prior to their freshmen year and saw each other on campus several times during their first months of school. Both David and Jessica were attracted to each other, but neither of them had ever dated before, so both were unsure how or when to ask the other out. Jessica eventually developed enough courage to ask David to attend a football game with her and some friends. They had a great time together and began seeing each other more often. David, meanwhile, decided to join a fraternity after being encouraged to do so by his roommate in the dorms. As the semester progressed, David and Jessica's relationship became official. They were boyfriend and girlfriend.

Vignette: David & Jessica

Near the end of the semester, David's fraternity brothers began making fun of him for only having kissed Jessica. They couldn't believe he had been dating a girl all semester and hadn't had sex with her. Although David and Jessica both seemed comfortable with their levels of intimacy, David began feeling the peer pressure. His friends were always talking about hooking up with various girls and he had no such stories to tell. He really like Jessica though and didn't want to move too fast.

In December of their freshmen year, David took Jessica to his fraternity formal. They had a great time and shared a hotel room with another couple. As the night concluded, David and Jessica laid down in bed together as they had previously. Both were more intoxicated than they had been in the past though. David cuddled up next to Jessica and began caressing her arms, stomach, and chest. Thinking Jessica was awake and comfortable with his touch, David moved his hand under Jessica's sweatpants and into her underwear. He began, for the first time in their relationship, touching her vagina. Jessica suddenly pushed David away. He didn't know what happened. She asked what he was doing. He said, "I thought you liked it." She said, "David, I was sleeping!" David felt awful.

Vignette: David & Jessica

The next morning things between Jessica and David were awkward. They packed up with their friends and returned to campus. They didn't talk for two days. The following day, David got an email from a person who identified herself as the "Title IX" Coordinator instructing him to come to her office. At the meeting, the Title IX Coordinator informed David that he had been accused of sexual assault and that he was to have no further contact with Jessica. He was dumbfounded.

During the investigation, David admitted to touching Jessica's vagina. In his defense, he claimed he thought she was awake and enjoying it. David was ultimately found responsible for violating his institution's sexual misconduct policy. Jessica feels bad for David, but she knows what he did was wrong and she thinks he needs to be held accountable for his actions. David now awaits the decision regarding what his sanction will be.

CFC for David

	INCIDENT CHARACTERISTICS	Yes	No	?
1.	Any non-consensual non-contact sexual conduct such as unwanted sexual remarks		X	
2.	Any verbal pressure to have sex stopping short of threatening physical harm		X	
3.	Verbal threats of physical harm directed at Complainant		X	
4.	Any non-consensual sexual touching	X		
5.	Any stalking of Complainant before or after incident		X	
6.	Any non-consensual oral, anal, vaginal penetration by the penis, fingers or objects	X		
7.	Multiple acts of penetration or more than one form of penetration within the same incident		X	
8.	Any non-consenting sexual acts involving multiple perpetrators		X	
9.	Any physical force, including use of body weight differences		X	
10.	Violence was gratuitous – it clearly exceeded what was minimally necessary to compel a nonconsensual sex act		N/A	
11.	Violence level escalated, such as kicking, punching, or choking, in response to resistance		N/A	
12.	Any injury to Complainant such as bruises, abrasions or sprains		X	
13.	Incident reported to the campus or community police ALTHOUGH HE WAS CALLED BY THE IX OFFICE, NO EVIDENCE THAT THE CAMPUS OR COMMUNITY POLICE WERE CALLED		X	
14.	Complainant obtained medical care (no evidence could score as no)		NO	
15.	Forensic evidence "rape kit" completed (no evidence could score as no)		NO	
	PRIOR MISCONDUCT			
1.	Any prior reports of academic misconduct		X	
2.	Any prior reports of physical aggression (e.g., fighting)		X	
3.	Any prior reports of non-consensual sexual kissing, touching, groping or other contact sexual misconduct		X	
4.	Any prior reports of using threats of harm or physical force, even minimal, to coerce nonconsensual, penetrative sexual acts		X	
5.	Any prior reports of non-academic conduct violations other than those mentioned above		X	

	ALCOHOL AND PEERS	Yes	No	?
1.	Any pressure on Complainant to drink alcohol NONE REPORTED		X	
2.	Intentionally gave complainant a spiked drinks/drinks without Complainant's knowledge		X	
3.	Any pressure on Complainant to consume drinks spiked with other drugs		X	
4.	Incident took advantage of an already intoxicated or stoned Complainant who was unable to consent - Unclear – although intoxicated, she clearly was "with it," and claimed he woke her up. THEY BOTH DRANK, THEY HAD A RELATIONSHIP, THEY HAD BEEN DATING. HE SAYS HE THOUGHT SHE WAS AWAKE. HE EITHER TOOK ADVANTAGE OF A SLEEPING PERSON, AND INTOXICATED PERSON OR HE DID THINK SHE WAS AWAKE AND WAS ENJOYING.			X
5.	Complainant was unconscious or passed out , or sleeping during all or some of the incident Modified in response to feedback. She reports she was sleeping, David thought she was awake.			X
6.	Any signs of excessive routine use of alcohol by Respondent, as evidenced by the number of days per week Respondent ingests alcohol and/or indications of binge drinking (more than 5 drinks per occasion)		X	
	IMPERSONAL BEHAVIORS			
1.	Complainant was a stranger		X	
2.	Complainant was known or recognized but had no prior consensual sexual behavior		X	
3.	Any involvement in recording pictures/videos of the incident		X	
4.	Any posting on Internet, or emailing/texting about the incident		X	
5.	Any remarks in which it seemed as if Respondent was conceited, bragging, boasting, or trying to impress the Complainant or other students/peers		X	
6.	Any remarks by Respondent to peers that suggested incident was viewed as a "sexual conquest"		X	
7.	Respondent evidences no concern for Complainant		X	
8.	Respondent known or suspected to associate with other students/friends/housemates that promote sexual "conquest" (including residence in an apartment or house that was the setting of other complaints in the past)	X		
9.	Respondent did NOT use a condom N/A		N/A	
10.	Respondent typically chooses sex partners based primarily on sexual availability, without emotional or other attraction as selection criteria. N/A FIRST TIME		N/A	

	HOSTILITY	Yes	No	?
1.	Use of verbal coercion that was not demeaning in nature, but highly manipulative		X	
2.	Any statements during or after that blamed the Complainant, such as "you like this," " you deserve this" or "you wanted this"		X	
3.	Any demeaning name-calling that was gender or sexual-orientation-focused, such as whore, bitch, cunt, twat, slut, queer, lezzie, dyke, fairy, fag/faggot		X	
4.	Any statements intended to demean or degrade the Complainant's race, ethnicity, religion or personal characteristics (such as being overweight)		X	
5.	Verbal threats of harm directed at Complainant		X	
6.	Respondent's responses reflected anger at Complainant and/or institution, or an affront or indignity towards them		X	

	POSSIBLE PROTECTIVE FACTORS	Yes	No	?
1.	Respondent accepts responsibility for the incident	X		
2.	Respondent currently involved in counseling/therapy NOT AT THE TIME THE CFC WOULD BE FILLED OUT		X	
3.	Respondent expresses willingness to be in therapy around current incident NO INFO			X
4.	Respondent has a moderate to strong academic record			X
5.	Respondent expresses some degree of remorse	X		
6.	Respondent appears to associate with healthy peers that do not actively promote sexual conquest			X

Vignette
Martin and Francesca

Vignette: Martin & Francesca

Martin is a married male graduate student who, as an undergraduate at a different institution, was an active member of his fraternity. Francesca is a female graduate student who is enrolled in the same cohort as Martin in a relatively small academic program.

About a year ago, Martin and Francesca met in class and began talking. Martin developed a romantic interest in Francesca which he made evident in various ways. Although attracted to Martin, Francesca was reluctant to reciprocate Martin's advances because she had recently ended a long-term relationship and because she knew Martin was married. Nevertheless, Martin and Francesca began a pattern of mutually flirtatious communication, which – according to Martin – resulted in them "hooking up" at a conference. Francesca, in contrast, believes Martin took advantage of her inebriation at the conference and talked her into having sex against her wishes.

Vignette: Martin & Francesca

When Francesca later confronted Martin about his behavior and her experience, Martin accused Francesca of provoking him and claimed the encounter was entirely consensual. Upset and humiliated, Francesca called Martin a "rapist" in a stairwell outside their classroom. Several classmates overheard and offered their support to Francesca as soon as Martin walked out.

The following day rumors started flying within their cohort and Martin was confronted by several peers. Martin then sent Francesca multiple text messages claiming she was "into it" and urging her to "stop this nonsense." When Francesca didn't respond, Martin sent a message to their cohort's private Facebook group seeking to explain himself, while also making a graphic reference to Francesca's breasts and claiming she was a "dicktease." Upset and humiliated, Francesca asked her Department Chair for help and a university investigation ensued.

Vignette: Martin & Francesca

Martin was ultimately found responsible for "sexual misconduct" because his behavior post-conference was determined to be sexually harassing in nature. The investigator, however, was unable to conclude, based on a preponderance of the evidence, that Martin violated institutional policy at the conference itself.

Martin now awaits the institution's decision regarding what sanctions will be imposed.

CFC Martin

	INCIDENT CHARACTERISTICS	Yes	No	?
1.	Any non-consensual non-contact sexual conduct such as unwanted sexual remarks (founded misconduct: Sexual Harassing) **Modified this to include everything in the case file, include the second incident which he was ultimately found responsible for.**	X		
2.	Any verbal pressure to have sex stopping short of threatening physical harm (more information)		X	
3.	Verbal threats of physical harm directed at Complainant		X	
4.	Any non-consensual sexual touching (although not found responsible for it, this behavior is alleged)		X	
5.	Any stalking of Complainant before or after incident		X	
6.	Any non-consensual oral, anal, vaginal penetration by the penis, fingers or objects	X		
7.	Multiple acts of penetration or more than one form of penetration within the same incident		X	
8.	Any non-consenting sexual acts involving multiple perpetrators		X	
9.	Any physical force, including use of body weight differences		X	
10.	Violence was gratuitous – it clearly exceeded what was minimally necessary to compel a nonconsensual sex act		N/A	
11.	Violence level escalated, such as kicking, punching, or choking, in response to resistance		N/A	
12.	Any injury to Complainant such as bruises, abrasions or sprains		X	
13.	Incident reported to the campus or community police		X	
14.	Complainant obtained medical care		X	
15.	Forensic evidence "rape kit" completed		X	

	PRIOR MISCONDUCT	Yes	No	?
1.	Any prior reports of academic misconduct		X	
2.	Any prior reports of physical aggression (e.g., fighting)		X	
3.	Any prior reports of non-consensual sexual kissing, touching, groping or other contact sexual misconduct		NO	
4.	Any prior reports of using threats of harm or physical force, even minimal, to coerce nonconsensual, penetrative sexual acts		X	
5.	Any prior reports of non-academic conduct violations other than those mentioned above		NO	
	ALCOHOL AND PEERS	Yes	No	?
1.	Any pressure on Complainant to drink alcohol		X	
2.	Intentionally gave complainant a spiked drink(s) without Complainant's knowledge		X	
3.	Any pressure on Complainant to consume drinks spiked with other drugs		X	
4.	Incident took advantage of an already intoxicated or stoned Complainant who was unable to consent	X		
5.	Was Complainant unconscious, passed out or asleep during all or some of the incident		X	
6.	Any signs of excessive routine use of alcohol by Respondent, as evidenced by the number of days per week Respondent ingests alcohol and/or indications of binge drinking (more than 5 drinks per occasion)		X	

	IMPERSONAL BEHAVIORS	Yes	No	?
1.	Complainant was a stranger		X	
2.	Complainant was known or recognized but had no prior consensual sexual behavior	X		
3.	Any involvement in recording pictures/videos of the incident		X	
4.	Any posting on Internet, or emailing/texting about the incident	X		
5.	Any remarks in which it seemed as if Respondent was conceited, bragging, boasting, or trying to impress the Complainant or other students/peers		X	
6.	Any remarks by Respondent to peers that suggested incident was viewed as a "sexual conquest"		X	
7.	Respondent evidences no concern for Complainant	X		
8.	Respondent known or suspected to associate with other students/friends/ housemates that promote sexual "conquest" (including residence in an apartment or house that was the setting of other complaints in the past)		X	
9.	Respondent did NOT use a condom			X
10.	Respondent typically chooses sex partners based primarily on sexual availability, without emotional or other attraction as selection criteria.			X
	HOSTILITY	Yes	No	?
1.	Use of verbal coercion that was not demeaning in nature, but highly manipulative	X		
2.	Any statements during or after that blamed the Complainant, such as "you like this," " you deserve this" or "you wanted this"	X		
3.	Any demeaning name-calling that was gender or sexual-orientation-focused, such as whore, bitch, cunt, twat, slut, queer, lezzie, dyke, fairy, fag/faggot ("Dick tease" – victim blaming item 2)		X	
4.	Any statements intended to demean or degrade the Complainant's race, ethnicity, religion or personal characteristics (such as being overweight)		X	
5.	Verbal threats of harm directed at Complainant		X	
6.	Respondent's responses reflected anger at Complainant and/or institution, or an affront or indignity towards them	X		

	POSSIBLE PROTECTIVE FACTORS	Yes	No	?
1.	Respondent accepts responsibility for the incident		X	
2.	Respondent currently involved in counseling/therapy			X
3.	Respondent expresses willingness to be in therapy around current incident		X	
4.	Respondent has a moderate to strong academic record			X
5.	Respondent expresses some degree of remorse		X	
6.	Respondent appears to associate with healthy peers that do not actively promote sexual conquest			X

Consider

- How will handoff's work between student conduct administrator and facilitator or clinician?
- How will communication be structured between clinician or facilitator and student conduct administrator?
- What information would the facilitator like to receive when the referral is made?
- What information would student conduct administrator like to receive from facilitator at the end of the AP or CBT program?
- What thoughts do you have regarding how facilitators will be selected?

SECTION V

Treatment Program

Overview of Treatment Program

- RNR framework – assess and tailor treatment based on risk and needs
  - Risk
  - Needs
  - Responsivity - includes incorporating different modalities (videos, writing assignments, role play).
- Based on empirically supported CBT techniques, incorporating elements from Motivational Interviewing and Dialectical Behavior Therapy
- Components
  - RNI-TV
  - 10 modules
    - Includes an average of 3 sessions per Module totaling approximately 30 sessions and includes individualized Out-of-Sessions Assignments.
    - Modules are sequential, but some may be omitted or combined depending on need/dosage.
  - Optional videos - in-house & web-based
  - Resources and supplemental materials
  - Experiential exercises
  - Ongoing consultation and support

Modules

- **Each consists of two or more sessions**
- **The therapist might not need to administer every module or session, and in some cases, might need to add a session for a module depending on the needs of the student client.**

Module 1: Orientation, Assessment & Treatment Planning
Module 2: Sexual Behavior & Sexual Abuse
Module 3: Focus on Socialization & Sexualization in Society
Module 4: A Perfect Storm: Understanding & Resolving Risks for Sexual Abuse
Module 5: Negative to Healthy Masculinity
Module 6: *Consequences* of sexual abuse
Module 7: *Behavior is a Choice*: Choosing wisely
Module 8: Developing healthy relationships
Module 9: Accountability: Making amends and making a difference
Module 10: Wrapping up & Going forward

Getting Started

Credentials: Recommend that providers (therapists) are licensed mental health professionals trained in clinical, counseling psychology, social work, or mental health counseling. Advanced doctoral and masters students, interns, and postdoctoral trainees are appropriate provided that they are supervised and follow whatever state requirements are necessary to practice (e.g., limited permit, insurance holder). **A note of caution -** if the student trainees also have interactions with other undergrad students in other contexts (e.g., teaching), they might not be appropriate because of potential dual roles.

Preliminary Preparation

•Training
•Recommend perusing the manual and familiarizing yourself with the materials
•Feel free to contact us at any time with any questions
•Consideration of HIPAA / Confidentiality issues
•Initial discussion between therapist and university to ensure communication guidelines

Getting Started

Primary tasks *prior to first session* with client:

- **Crucial -** therapist discuss what the university is expecting in terms of termination/completion summary and other communication
- If therapist is not comfortable with what is being proposed/expected, there must be a negotiation arriving at a mutually accepted resolution consistent with professional practice guidelines, FERPA, HIPAA and confidentiality limits.
- **Informed consent with student client:** Ensure transparency with the student; whatever is agreed upon in terms of reporting to the university must be communicated to the student at the first session, as well as how additional information requested post informed consent will be handled.
- **Gray Area:** between absence of confidentiality in forensic context and close to full confidentiality in conventional clinical practice.
- **Concern:** although students typically not adjudicated, they could be in the future.

Informed Consent

- ❖ Burden on therapist
- ❖ Clear understanding of the limits of confidentiality
- ❖ Clear understanding of what will be shared with the university
- ❖ Clear communication of procedure: how the therapist will handle requests for additional information (i.e., not originally requested)
- ❖ Mindful of potential harm, clinical contraindications
- ❖ Recommend: signed documentation outlining these specifics – two copies (student and therapist)
- ❖ Consent for release of information (i.e., CFC, incident reports, student records) from student client

Risk-Needs Inventory Test Version (RNI-TV)

Risk Needs Inventory

- **To assess empirically-informed dynamic risk factors**
- **Rated from:**
  0 - **not present, or minimal need** and/or significant progress
  1 - **moderate need** and/or some progress; indicates a need for improvement
  2 – **significant need** and/or no progress
- **RNI-TV assessment occurs at a minimum of two times, three is preferable**
  - Initial assessment: Module 1 (sessions 1 and/or 2)
  - Upon completion: Reviewed with client in Module 10
    - Clinician completes RNI-TV
    - Clinician and student client both complete the RNI-TV, independently
    - Clinician and student client complete the RNI-TV together
- **Corresponding Risk Needs Interview-TV**
  - Provides examples of information and questions for each item as a place to start; lays the groundwork for fodder for further discussion
  - Can be subsumed in the context of a larger psychosocial initial intake interview

Risk Needs Inventory

- RNI items are phrased in a valence neutral manner to capture strengths & protective factors, as well as risk factors associated with sexual recidivism.
- They are rated on a 0-2 (0=absent, 1= somewhat present, 2= clearly present) basis.
- Higher ratings reflect greater criminogenic / treatment needs.

RNI-TV Criminogenic Items
(research support linking to sexual recidivism)

- ➢ Sexual Self-Regulation
- ➢ Attitudes/Beliefs Regarding Sexual Misconduct
- ➢ Behavioral Self-Regulation
- ➢ Emotional Self-Regulation
- ➢ Alcohol Use and Abuse (specific to campus misconduct lit.)
- ➢ Social Orientation and Engagement (Prosocial v Antisocial)
- ➢ Social Competence
- ➢ Peer Relationships / Peer Pressure
- ➢ Intimate Relationships and Sexual Behavior
- ➢ Mentors or other Positive / Prosocial Supports

Likely <u>indirect</u> criminogenic effects

- ❖ Accepting Responsibility for <u>all</u> Sexual Behavior (an internal LOC)
- ❖ Victim Impact / Empathy
- ❖ Regret /Remorse for Sexual Misconduct
- ❖ Research support is very limited, especially as it pertains to treatment. However, these are examples of "secondary" issues that may clearly be related to the behavior of concern, e.g., broader issues of taking responsibility for most of one's behavior, feeling regret for wrongdoing generally.

Responsivity Needs

What does this student need to be maximally responsive to treatment?

- When clinicians are working with LGBTQI students, they must become culturally aware of unique criminogenic needs that may be specific to those students. Issues around sexual orientation and sexual identity may be in the forefront, along with anger, depression, and self-acceptance
- The same holds for clients that are women. Family / relationship problems, for example, tend to be more robust for females than for males.

Risk Needs Inventory

SEXUAL MISCONDUCT
RISK & NEEDS INVENTORY- TEST VERSION (RNI-TV)

Name: _____ Birth Date: _____
Note: Intake ____ Interim ____ or Final ____ Dates covered: _____
Treatment status: Active _____ Refused _____ Dropped out _____ Completed _____
Number of sessions this period: Offered _____ Completed _____ Refused _____

Treatment Objectives/ Needs	No/Minimal Need or Significant Progress	Moderate Need/ Progress	Significant Need
1. Accepting Responsibility for All Sexual Behavior	0	1	2
2. Internal Motivation for Change	0	1	2
3. Sexual Self-Regulation	0	1	2

Risk Needs Inventory

Treatment Objectives / Needs	No/Minimal Need or Significant Progress	Moderate Need/ Progress	Significant Need
1. Accepting Responsibility for All Sexual Behavior	0	1	2
2. Internal Motivation for Change	0	1	2
3. Sexual Self-Regulation	0	1	2
4. Attitudes/Beliefs Regarding Sexual Misconduct	0	1	2
5. Regret /Remorse for Sexual Misconduct	0	1	2
6. Victim Empathy / Impact	0	1	2
7. Behavioral Self-Regulation	0	1	2
8. Emotional Self-Regulation	0	1	2
9. Alcohol Use and Abuse	0	1	2
10. Social Orientation and Engagement	0	1	2
11. Social Competence	0	1	2
12. Peer Relationships	0	1	2
13. Intimate Relationships and Sexual Behavior	0	1	2
14. Mentors or Other Prosocial Supports	0	1	2
15. Other*	0	1	2

Item 1: Accepting Responsibility for All Sexual Behavior

Includes

- Accepting full responsibility for all sexual behavior
- Safe and consensual sexual behavior
- No excuses, denying, disowning, minimizing, redirecting or ascribing blame/responsibility to someone else or circumstances (e.g., victim blaming, alcohol, parties, society)

Interview suggestions/Helpful hints

- Begin with social and sexual history
- Obtain information about times when they have initiated sexual activities and the context of such, client's perceptions about their own role in sexual encounters

Item 2: Internal Motivation for Change

Includes

- Extent to which the student client experiences sexual misconduct as "out of character"
- Genuine desire to change his/her behavior and avoid for misconduct

Interview suggestions/Helpful hints

Starting questions that can serve as fodder for further discussion

- Is there anything about yourself that you would like to change?
- What, if anything, would you like to change (remain the same)?
- Since the incident, what if any changes have you noticed about yourself/behavior?
- Confidence level to change (scale of 1-10)

Item 3: Sexual Self-Regulation

Includes

- Appropriate management of sexual regulation
- Not excessively sexually preoccupied (thoughts, fantasies, behaviors)
- Consider this within a **6 month time frame** (last 6 months)

Interview suggestions/Helpful hints

- Ask about periods of increased/decreased desire/activity
- Periods of excessive/compulsive activity
- Have you ever used sexual activity (with another person) to modify your emotional state, or as a coping strategy?
- Have you ever masturbated to change your emotional state?
- If they have used sexual activity to self-regulate, ask about other self regulation strategies – what has worked, what didn't
- Pornography consumption
- Include the Internet

Item 4: Attitudes/Beliefs Regarding Sexual Misconduct

Includes

- Attitudes and beliefs that support or justify sexual misconduct

Interview suggestions/Helpful hints

Starting questions that can serve as fodder for further discussion

- Do you ever think that sometimes the way a person dresses suggests that they are looking for sex?
- Do you think that some people give mixed messages when it comes to sex?

Item 5: Regret /Remorse for Sexual Misconduct

Includes

- Truly expresses/demonstrates regret/remorse
- Differentiate between genuine statements and socially desirable, intellectualized statements

Interview suggestions/Helpful hints

Starting questions that can serve as fodder for further discussion

- Was there ever a time when you engaged in a sexual behavior that you regretted?
- (If yes) What do you think that experience was like for the other person?
- Note affect when exploring this

Item 6: Victim Impact / Empathy

Includes

- Affective capacity to appreciate the impact of his/her behavior on the victim and others.
- Differentiate between statements that reflect genuine victim empathy from those that are intellectualized, self serving and/or socially desirable.

Interview suggestions/Helpful hints

- Look for affective reactions when the student client is talking about his/her behavior
- Evidence of it seeming staged or like a speech
- *What do you imagine life has been like for the other person involved?*

Item 7: Behavioral Self-Regulation

Includes

- General behavioral management (nonsexual behaviors).
- Look for poor behavioral or emotional regulation strategies such as acting impulsively, without consideration of consequences (e.g., reckless driving), substance use
- Appropriate self-regulation: exercising good judgement, age-appropriate problem solving skills, and considering consequences and options
- Consider school records and other sources
- Consider this within a **6 month time frame** (last 6 months)

Interview suggestions/Helpful hints

- Ask about a history of behavior problems in different contexts (home, elementary and secondary school), diagnosis of ADHD, school fights, suspensions, history of impulsive behaviors (fire setting, gambling, reckless driving)
- Did you ever see a counselor of therapist because of behavioral problems?
- Have you had any problems managing your anger?

Item 8: Emotional Self-Regulation

Includes

- Ability to regulate emotions, particularly in stressful situations.
- Instances when the student client has lost control, is argumentative, and/or passively withdraws and does not express feelings
- Consider this within a **6 month time frame** (last 6 months)

Interview suggestions/Helpful hints

Starting questions that can serve as fodder for further discussion

- Do you consider yourself a very emotional or sensitive person?
- Has anyone every said to you that you have difficulties when faced with emotional situations?
- Do you tend to avoid emotions or emotionally charged situations, relationships?
- Do you ever experience emotions that seem so intense or overpowering that you are concerned about how you will get through and manage them?
- How do you typically handle stressful situations?
- What do you typically do when you are upset, angry, etc?
- How do you typically deal with problems?

Item 9: Alcohol Use and Abuse

Includes

- Problematic alcohol use that includes excessive consumption, including binge and competitive drinking, as well as negative effects of alcohol consumption (e.g., becoming hostile, belligerent).
- Negatively impacts functioning or areas of his/her life (e.g., academic/work performance, interpersonal relationships, legal problems)
- Consider this within a **6 month time frame** (last 6months)

Interview suggestions/Helpful hints

- Recommend obtain information about drug and alcohol history
  - Type
  - For each substance: age of first use, typical quantity use, frequency, route of administration, loss of consciousness
  - Tolerance
  - Consequences
  - Treatment history
  - Periods of abstinence
  - Sexual activity while under the influence
  - Risky behaviors while under the influence
  - Ever use substances on another person to make it easier to have sex with them?

Item 10: Social Orientation and Engagement

Includes

- Attitudes and behaviors consistent with prosocial orientation.
- Interest in volunteer and campus activities
- Good friendships, positive experiences with other people
- Capacity to demonstrate healthy attitudes about others and social situations
- Interest in social exchanges
- The absence of any patterns of rule breaking or antisocial behaviors (violating the law, defiance of authority
- Consider this within a **6 month time frame** (last 6months)

Interview suggestions/Helpful hints

- Obtain a history of relationships with friends and family
- Preference to being with others versus alone; actively seek our social situations ?
- Interest and frequency of social activities, including clubs, organizations
- Relationships in professional, employment contexts too
- Challenges with people (look for patterns)

Item 11: Social Competence

Includes

- Cognitive, social and emotional skills for developing and maintaining healthy interpersonal relationships
- Individuals knowledge and abilities for successfully engaging and maintaining appropriate interpersonal and romantic/intimate relationships
- Exercises good judgment with respect to negative peer influence and refrains from participating in negative social behaviors

Interview suggestions/Helpful hints

If they endorse interpersonal relationships, may ask the following about their relationships

- Why the relationship is important?
- Qualities that they value about the relationship
- Important aspects of the relationship
- What do they value about the person?
  - Why do they think they are close to the person?
  - What types of behaviors might be harmful to relationships?
  - Obtain a sense of their beliefs of relationships and what they might have been taught by their family of origin.

Item 12: Peer Relationships

Includes

- Nature of the student client's peer relationships
- Quality
- Consider this within a **6 month time frame** (last 6 months)

Interview suggestions/Helpful hints

- Number of friends, quality of relationships (superficial, engaged, exploitative?)
- Look for association with negative peer groups
- Influence of peers on student
- Changes in friendships, why (pattern?)
- Current relationships with peers in college

Item 13: Intimate Relationships and Sexual Behavior

Includes

- Quality of intimate relationships
- Healthy qualities such as sharing one's thoughts, feelings and experiences with others
- Having an emotional connection
- Healthy sexual intimacy

Interview suggestions/Helpful hints

- May start by obtaining relationship and sexual history
- If needed: See Manual for additional questions for gender and sexual orientation are available for LGTBQI student clients

Item 14: Mentors or Other Pro-social Supports

Includes

- Availability and appropriate use of positive support systems
- Parents, other family members, teachers, school administrators, coaches, employers, religious leaders, therapist/counselor, etc.
- Participation in organized community activities that promote respectful relationships

Interview suggestions/Helpful hints

- With whom?
- Nature of the relationship?

RNI Exercise

Vignette
Martin and Francesca

Vignette: Martin & Francesca

Martin is a married male graduate student who, as an undergraduate at a different institution, was an active member of his fraternity. Francesca is a female graduate student who is enrolled in the same cohort as Martin in a relatively small academic program.

About a year ago, Martin and Francesca met in class and began talking. Martin developed a romantic interest in Francesca which he made evident in various ways. Although attracted to Martin, Francesca was reluctant to reciprocate Martin's advances because she had recently ended a long-term relationship and because she knew Martin was married. Nevertheless, Martin and Francesca began a pattern of mutually flirtatious communication, which – according to Martin – resulted in them "hooking up" at a conference. Francesca, in contrast, believes Martin took advantage of her inebriation at the conference and talked her into having sex against her wishes.

Vignette: Martin & Francesca

When Francesca later confronted Martin about his behavior and her experience, Martin accused Francesca of provoking him and claimed the encounter was entirely consensual. Upset and humiliated, Francesca called Martin a "rapist" in a stairwell outside their classroom. Several classmates overheard and offered their support to Francesca as soon as Martin walked out.

The following day rumors started flying within their cohort and Martin was confronted by several peers. Martin then sent Francesca multiple text messages claiming she was "into it" and urging her to "stop this nonsense." When Francesca didn't respond, Martin sent a message to their cohort's private Facebook group seeking to explain himself, while also making a graphic reference to Francesca's breasts and claiming she was a "dicktease." Upset and humiliated, Francesca asked her Department Chair for help and a university investigation ensued.

Vignette: Martin

Martin was ultimately found responsible for "sexual misconduct" because his behavior post-conference was determined to be sexually harassing in nature. The investigator, however, was unable to conclude, based on a preponderance of the evidence, that Martin violated institutional policy at the conference itself.

Martin now awaits the institution's decision regarding what sanctions will be imposed.

Vignette
Martin and Francesca
(continued)

Vignette: Martin & Francesca Supplemental Information

Martin has been suspended from the institution for a semester and instructed to complete an appropriate treatment program.

During the first session with his therapist, Martin presents as strong-headed and resistant to change. He's clearly very smart, but quite immature emotionally. He believes he did nothing wrong. He said Francesca clearly "wanted it," and noted she knew he was married but "came after" him anyway. He reported he is just participating in this program to get back to school as quickly as possible.

Martin reported that he got in legal trouble in high school for "little stuff" like "joyriding" (i.e., taking someone's car for a spin without permission) and "other minor things." He said he used to drink "a bunch" in college with his fraternity brothers when they played beer pong with the girls, but rarely does so anymore because he likes to be "in control." When asked whether he ever was questioned about engaging in sexual misconduct as an undergrad, he said some girls got drunk at one of their fraternity parties and falsely accused him and a couple of his friends of spiking their drinks and having sex with them. He added, "I don't need to spike anyone's drink to have sex with them."

Martin acknowledged he gets frustrated and loses his temper with his wife sometimes when she complains about him coming home late from the bars, but denied any physical altercations. According to Martin, they got married because she was pregnant, but then she miscarried late in the pregnancy. Martin complained his wife expects him home every night and added that Francesca had been a breath of fresh air until she started all this trouble.

Martin appears to be someone who is superficially smooth and charming, but has difficulty forming and maintaining close attachments. He described no close friends, just acquaintances. Although he values school and working toward being a computer programmer, he has no special mentoring relationships with faculty or other positive supports.

According to Martin, his wife still knows nothing about this incident or his relationship with Francesca. She also doesn't know he has been suspended. He would like to keep it that way and asks several questions, including "How long will this take?" and "Are you gonna try to make me tell my wife?" Outwardly self-confident, Martin also says, "I'm really not a bad person; I just know what I want and I go after it. This whole thing with Francesca has taught me a lot though. Some girls really are crazy. The best I can do in the future is try to avoid them."

Martin
RNI

Treatment Objectives/ Needs	No/Minimal Need	Moderate Need	Significant Need
1. Accepting Responsibility for All Sexual Behavior	0	1	**2**
2. Internal Motivation for Change	0	1	**2**
3. Sexual Self-Regulation	**0**	1	2
4. Attitudes/Beliefs Regarding Sexual Misconduct	0	1	**2**
5. Regret /Remorse for Sexual Misconduct	0	1	**2**
6. Victim Impact / Empathy	0	1	**2**
7. Behavioral Self-Regulation	0	1	**2**
8. Emotional Self-Regulation	0	1	**2**
9. Alcohol Use and Abuse	0	**1**	2
10. Social Orientation and Engagement	0	**1**	2
11. Social Competence	0	1	**2**
12. Peer Relationships	0	1	**2**
13. Intimate Relationships and Sexual Behavior	0	1	**2**
14. Mentors or Other Prosocial Supports	0	1	**2**
15. Other*: N/A	0 **N/A**	1	2

- **Martin had points on all but one domain.**
- Martin has significant needs in these domains as well as emotion and behavioral self-regulation problems and increased antisocial attitudes and beliefs. He may have strong dependency needs on his wife as well as to be positively affirmed by women (perhaps hence is rage at the complainant and his sexual posting to embarrass her), although he certainly does not treat his wife with respect as he hangs out at bars and hooks up with other women.
- Specific concerns about Martin?

Each Module includes:

- ❖ **Narrative for clinician describing the clinical focus of the Module, "core" treatment targets of the module, and discussion points; training resources for the clinician as well as treatment resources for the client**
- ❖ **These Modules may also include additional resources, as deemed appropriate:**
  - ✓ Videos / video clips / YouTube links for selected Modules
  - ✓ Experiential exercises for selected Modules
  - ✓ Out of session assignments (OSAs) for selected Modules
- ➢ **Each consists of two or more sessions**
- ➢ **Therapist might not need to implement every session or might need to add a session for a module depending on the needs of the student client**
  - ✓ Selected readings

Snapshot of Modules

Treatment Modules

❖ **Module 1: Orientation, Assessment & Treatment Planning**

- **Session 1: Orientation & Assessment.**
  Why are you here; What is my (therapist's role); What do we hope to get out of this; What are the "ground rules"? What happens when we're done?
- **Session 2: Assessment. Treatment planning.**

❖ **Module 2: Sexual Behavior & Sexual Abuse**

- **Session 1: Sexual Behavior & Sexual Assault: How they differ?**
  What IS sexual assault? / other forms of abuse – bullying, harassment, stalking, Internet abuse
- **Session 2: Relationships & consent: What is consent?**
  Consent & parties; Consent & alcohol; Consent & drugs; Consent & Hook-ups; Consent & Date #1
- **Session 3: Sex & the law**
  (including criminal law parameters, Clery definitions, civil suits, and more)

❖ **Module 3: Focus on Socialization & Sexualization in Society**

- **Session 1: Gender socialization & Sex**
  Gender roles, sex & messages in the media
- **Session 2: College campuses and a hook-up culture , FWB, partying, casual / no commitment**
- **Session 3: Peer influences, negative group psychology and erroneous beliefs**

❖ **Module 4: A Perfect Storm: Understanding Risks for Sexual Abuse**

- **Session 1: Risky / Irrational Attitudes**
  Sexual entitlement, distorted attitudes about women, sexuality & relationships
- **Session 2: Risky feelings**

Conceit, arrogance, vanity, jealousy, possessiveness, anger

- **Session 3: Risky behaviors, sexualized language, frequent pornography use, alcohol**
- **Session 4: Risky situations, partying, drinking games, negative peer influence**
- **Session 5: A Perfect Storm: drinking & partying; irresponsible use of alcohol & drugs; deceptive use of drugs to facilitate sexual assault; peer influence**

❖ **Module 5: Healthy Sexual Identity & Sexual Behavior**

- **Session 1: *Hostile* or *negative* masculinity**
  Where does it come from, what does it "look like," what does it do to our friendships, our relationships, and our partnerships with others; why is it so important?; sexual privilege – sexual entitlement; distorted attitudes about sexuality, women, relationships; what is misogyny – misogyny & relationships
- **Session 2: *Healthy masculinity***
- **Session 3: *Healthy masculinity and gay men***
  Unique issues and struggles around masculinity for gay men; how do issues and attitudes around masculinity express themselves in sexual abuse in gay relationships & outside of relationships
- **Session 4: Healthy femininity & gender identity for women**
  Healthy gender identity for women; how does gender identity contribute to healthy hetero, homo, or bisexual relationships; how struggles, problems & challenges in female gender identity contribute to sexual misconduct or abuse

❖ **Module 6: *Consequences* of sexual abuse**

- Session 1: Effects on survivors
- Session 2: Impact on friends, family, community and self

❖ **Module 7: *Behavior is a Choice*: Choosing wisely**

- Session 1: ABC'S of human behavior
- Session 2: Recognizing and managing risky thoughts, feelings, behavior & situations)
- Session 3: My values & goals: who I am and who I want to be
- Session 4: Making good choices (problem solving)

❖ **Module 8: Developing healthy relationships**

- **Session 1: Friendships and partners**
  Taking stock. Expectations, hopes, & goals. What are healthy relationships?
  Types of relationships: Acquaintances, 1st date, FWB, Hook-ups, etc.
- **Session 2: Perspective taking & Empathy**
  Understanding and *caring* about the needs, wants, and feelings of others
- **Session 3: Communicating effectively**
  Interpersonal – "dating" skills
- **Session 4: Developing positive relationships**
  That reflect equality & compromise rather than gender-stratified roles & obligations, or one-sided, inequitable dynamics based on dominance
- **Session 5: How does sex fit in my life?**
  Attitudes, feelings, behavior; safe sex.
- **Session 6: Ensuring consent**

❖ **Module 9: Accountability: Making amends and making a difference**

- **Session 1: Recognizing harm done & apologies (if appropriate)**
- **Session 2: Bystander interventions. Preventing victimization**

❖ **Module 10: Wrapping up & Going forward**

- **Session 1: What I have learned? Assessment & Feedback**
  What was learned, positive changes / treatment gains
- **Session 2: Plans for healthy living. Assessment & Feedback**
  What to be mindful of / warning signs / "hooking-up" with responsible, prosocial peers / re-entering college

Completion of Treatment

Summary based on agreement between university and therapist for information about treatment completion.

Suggestions

Treatment: number of sessions, duration of tx (months), missed sessions w/o prior notification, successful completion (if no, specify reason)

Client's response: (general statements about):
-Level of motivation, engagement and participation
-Treatment gains and progress towards treatment goals
-Positive changes in attitudes and behaviors
-Areas of strength/protective factors at discharge
-Client's plans for risk management and safe healthy future behavior

Core areas of risk/concern at discharge

What can we conclude (based on our very limited data) about clinical / TX needs of Martin and David?

- *See document linking RNI-TV items to specific modules

Martin

- **Overview: Key Features**

- **Married – infidelity – victims says she knows – apparently no secret**
- **Attending a conf. together after flirting – she was drunk, he talked her into having sex against her wishes – no details about what was "against her wishes"**
- **She confronts him about his behavior**
- **He accuses her of "provoking" him & claimed it was consensual**
- **She: upset, feeling humiliated, calls him a rapist**
- **He sends her text messages – "you were into it" ; "stop this nonsense"**
- **She doesn't respond**
- **He posts message to Facebook calling her a "dick tease" and making a comment about her breasts**
- **She – humiliated – reports him to the dept. chair / univ. investigation ensues**

Martin: Major Issues

- He ignores her non-consent
- He blames her – she "provoked" him
- He is clearly insensitive & unempathic
- He trivializes it – "stop this nonsense"
- He escalates – publically calling her a dick tease and his public remark about her breasts
- She finally reports him
- Possible different outcome if there was an apology, expression of remorse?

Martin: Major Risk Factors

- Ignores non-consent
- Evidences no empathy / trivializes / blames victim
- Publically shames victim / anger / crass insensitivity
- Infidelity suggests larger issue of impersonal relationships with women

Treatment Needs

- Understanding when sexual behavior becomes abusive
- Understanding that sex absent consent is not just "wrong" but it is a crime
- Understanding consent and how to ensure it.
- Understanding that ensuring consent = positive masculinity versus stealing sex
- Addressing victim impact (with someone who may have some significant deficits)
- Enhancing emotion and behavioral regulations skills
- Addressing intimacy needs, relationships with women, prosocial mentors and peers (no evidence of any ongoing positive friendships).

Martin - Treatment Planning

*Bold denotes significant tx need

- **Accepting responsibility for all sexual behavior**
  - Module 2 – range of sexual misconduct behaviors; CERTS model and material
  - Student discussion videos about consent & accountability
  - Module 4 – risky situations – discuss conference and alcohol. Exercises where you ask Martin to identify risky situations – what was attractive, enjoyable (Francesca seemed like a breath of fresh air)
  - Discuss how alcohol impacts consent
  - Possible prior past acts of misconduct – explore, identify
  - Infidelities?

Martin - Treatment Planning

*Bold denotes significant tx need

- **Internal motivation for change**
  - Module 1 – Motivational enhancement & engagement
  - Module 7 – five step decision making process; antecedents and consequences, functional analysis of behavior
  - Module 7 – values; motivational enhancement, explore values; what does Martin value (relationship with wife)?
- **Attitudes/beliefs regarding sexual misconduct**
  - Module 8 – Activities highlight what is sexual assault and consent

Martin - Treatment Planning

*Bold denotes significant tx need

- **Regret/Remorse for sexual misconduct**
  - Exercise in manual on empathy versus sympathy
  - Student discussion video consequences for victims
  - Module 9, session 2 – explore ideas on how to make amends (volunteer), exercise discussing the men who intervened in the Stanford rape case
- **Victim Impact/Empathy**
  - Victim Perspective STARRSA Video
  - STARRSA materials about impact
  - Vignette exercise – Appendix (Pg. 141)
  - Victim Map experiential exercise
  - Sexual assault impact experiential exercise
  - Module 6, session 2 - impact to others (e.g., Francesca's friends, relatives but also Martin's wife)

Martin - Treatment Planning

*Bold denotes significant tx need

- **Behavioral Self-regulation**
  - Module 4 and 7
  - Recognizing the deficits and needs, skills building, Linking behavioral responses to consequences, problem solving skills
- **Emotional Self-regulation**
  - Module 4 and 7
  - Recognizing the deficits and needs, skills building, Understanding the connection between emotions, thoughts, and behaviors, problem solving skills
- Alcohol Use
  - Module 4, session 5
  - Understanding impact on thoughts, behaviors, decision making
  - Function it serves for him?
- Social orientation and engagement
  - Module 3, peer influence
  - Module 8, sessions 1 and 2
  - Focus on his past history of rule violations, explore prosocial activities, benefits of such?
- **Social competence**
  - Module 7, session 1-3
  - Modules 5, 8, 9
  - Recognition of deficits and needs, develop skills, challenge his plan to "avoid them" (women like Francesca) in the future, develop a realistic plan.

Martin - Treatment Planning

- **Peer Relationships**
  - Module 3, session 3
  - No close friends, just acquaintances – explore this; develop positive peer relationships compared to past peers.
- **Intimate relationships and sexual behavior**
  - Module 8, session 2
    - Discuss his goals, values, relationship with his wife
    - Exercise where you ask him how one demonstrates that they care for someone; who has he cared for; who has cared for him
- **Mentors or Other Prosocial Supports**
  - Module 8, session 4
  - He values school, but does not have mentors – explore the benefits of such

SECTION VI

Psychoeducation Defined

'The process of disseminating information about the nature of a disorder for the purposes of fostering attitudinal and behavioral change in the recipient. It is a didactic process whereby the practitioner thoughtfully distills and summarizes relevant scientific information about a disorder to address such questions of the patient as "Why did I develop this problem? What can I do to get better?"' (Davis, Olmsted, & Rockert, 1990)

"Psychoeducation is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions….It is based on strengths and focused on the present" (Lukens and McFalane, 2004).

Psychoeducation

- Traditionally used and effective for
  - Health issues (e.g., diabetes, coronary heart diseases)
  - Medication management with medical and mental health conditions (e.g., bipolar, schizophrenia)
  - To teach family members how to recognize the signs and symptoms and assist in providing help and support to a loved one living in the community with a serious mental illness management in the community (e.g., schizophrenia)

Psychoeducation Current Uses

- As a stand alone intervention
- As part of stepped interventions
  - Effective (Patel et al., 2011 for individuals with depression and anxiety)
- Incorporated into psychotherapy and other psychological interventions
  - Highly effective when viewed as a whole program
    - CBT
    - DBT
    - Seeking Safety

Summary of Psychoeducation Effectiveness

- **Support for effectiveness to:**
  - Increase knowledge and understanding
  - Increase treatment compliance/engagement
  - Awareness of symptoms
- **Some support for (varies by condition, outcome measures):**
  - Changes in attitudes
  - Changes in behaviors
  - Changes in quality of life variable, positive enhancement, improvements in mood, decrease stress

Overall, psychoeducation is most effective when:

- Intervention is of sufficient duration (usually longer term)
- Content is organized, had clear target goals, but is flexible
- Facilitators are well trained and maintain fidelity to an evidence-based curriculum (e.g., thorough supervision and outcome measurement)
- Facilitators have access to consultation or supervision
- Facilitators have strong communication skills
- When provided in group to promote discussion, exchange of information
- Active and engaged, as opposed to passive

Why do we call our program "Active Psychoeducation?"

- Psychoeducation is rarely a standalone intervention for serious complex, unwanted behavior. Passive presentation of knowledge is *necessary but not sufficient* to change behavior.
- Need to consider other factors. In cases where there are additional problems, comorbid (co-occurring) conditions, chronic patterns, psychotherapy is appropriate.
- For that reason, we have attempted to infuse our program with "activities" that reinforce the educational messages. Hence, we call it "Active Psychoeducation"

Psychoeducation Objectives

- Individualize and maximize the effectiveness of interventions through evidence-based assessment to identify risks and needs.
- Engage the student in the assessment and the intervention process by identifying positive outcomes that can result from participating in the program.
- Increase knowledge and awareness about topics relevant to sexual misconduct (e.g., consent).
- Help student improve self-monitoring, and decision-making.
- Provide education about dynamic risk factors associated with sexual misconduct and related needs while supporting and increasing the student's strengths and protective factors.

A Slippery Slope: Suggested Guidelines

To maintain the parameter and avoid engaging in psychotherapy:

- Recognize that given the topic and nature it is easy to venture into the psychotherapeutic arena
- Inform the student of the nature and focus of psychoeducation and the goals of the intervention.
- Maintain focus on topic and content
- Redirect back to topic and content
- Consider referring to psychotherapy or a consult when appropriate
- Consult with team for suggestions after session; consult with colleagues

Getting Started and Guidelines for success

- Review relevant information from student conduct professionals
- **Agreement form (analogous to consent)**
  - Clear and accurate
    - Not psychotherapy
    - Not confidential (information may be shared with other university officials - consider institutional policy as well as relevant laws)
      - Other acts of sexual aggression may be reported to law enforcement (facilitators affiliated with the university only)
    - Goals
    - What will happen
    - Information – shared by who
- Be aware of warning signs for the need to refer or obtain consultation/supervision from a licensed mental health professional
- Impact to facilitator/vicarious trauma

Red Flags

These are highly unlikely, but if encountered, please consider responsibilities to connecting the student to resources to ensure everyone's safety

- Excessive displays of emotions or emotional displays incongruent with the topic discussed.
- Disclosure of suicidal or homicidal thoughts, actions, self-injurious behaviors. Statements that convey danger to self or others (may require immediate action in accordance with university guidelines)
- Significant distress or endorsement of significant symptoms that require a mental health professional (e.g., severe anxiety, depression, hallucinations, excessive activity, persistent lack of sleep, unusual behavior, increasingly poor hygiene, unkempt).
- Threats to the facilitator or others – overt and/or veiled
- Repeated disclosures of highly personal information despite redirections, explicit instructions. Asking for help with personal problems.
- Inappropriate requests: trying to be friends with the facilitator or spend time with the facilitator outside the program.

Managing Red Flags

- Preparation
  - Understand and know how to execute your university's process and procedures for students in immediate need of assistance
- Differentiate between flags that require immediate intervention and those that do not. Obtain help for those that require immediate intervention
- Consultation with the STARRSA team
- Consultation with Student Counseling Center, appropriate university colleague
- Consider referring for a mental health evaluation
- Consider referring to the treatment program

AP Approach

- AP Program begins with a brief assessment that guides the facilitator to the most critical areas to target.
- Initial and periodic re-assessment help to adjust the amount of time and focus needed for each Module.

AP Approach

- Although the facilitator could touch upon each of the 10 Modules, it is not required, nor is it even expected.
- Administered individual rather than group format.
- What is more important is an informed understanding of the most critical risk factors that need to be addressed for a given individual.
- Duration depends on assessed risks and needs and may involve 8-10 sessions.
- The number of the sessions is based on number of needs and the time required to address adequately each of them.

David

- David primary criminogenic needs are negative peer influences / peer pressure and negotiating intimate relationships, including, most notably, communication skills with women.
- David clearly needs to understand what consent means. The fact that he claimed he thought Jessica was awake may suggest that he needs assistance with social cues.
- Understanding the possible harm of his actions

- He presents as generally prosocial, perhaps ashamed, and sorry that he hurt, and lost, his girlfriend. He is likely to grasp the treatment concepts easily and is likely to progress quickly in treatment. Though he too might well be angry at first and reject the idea that he needs to be in treatment (especially if his fraternity brothers get to him).
- He may not need much work on negative masculinity, except perhaps to better understand the negative peer influences.

- He may not even need much on the alcohol / partying scene.
- Although he expresses remorse about hurting Jessica, he does not seem to understand the impact of the behavior. Suggestion that he needs some work regarding victim impact, he probably already understands how stranger and acquaintance rape can harm.

- Understanding how his violation = sexual assault and can be harmful is critical.
- Showing him videos about more serious sexual assaults may not be helpful as they will not resonate with him and he is likely to dismiss them as having nothing to do with him.
- He might be able to generate ideas himself perhaps through some therapeutic guidance and exercises.

- He presents as generally prosocial, perhaps ashamed, and sorry that he hurt, and lost, his girlfriend. He is likely to grasp the treatment concepts easily and is likely to progress quickly in treatment. Though he might well be angry at first and reject the idea that he needs to be in treatment (especially if his fraternity brothers get to him).
- He may not need much work on negative masculinity, except perhaps to better understand the negative peer influences.
- He may not even need much on the alcohol / partying scene.
- Although he clearly needs some work regarding victim impact, he probably already understands how stranger and acquaintance rape can harm.
- Understanding how his violation = sexual assault and can be harmful is critical, but showing him videos about much more serious sexual assaults may not be helpful as they may not resonate with him. He might be able to generate ideas himself perhaps through some therapeutic guidance and exercises.

Psychoeducation Plan for David

- Motivation to Change
  - Module 1: Establish goals and purpose.
  - Module 7: help student define values and goals and the relationship between the two; learn how values and goals develop; assist student in identifying their own values and goals and how poor decision making contributed to his/her current situation. Provide psychoeducation about the relationships between good decision-making and values, life goals, and objectives.
  - Module 10: reiterate, reinforce psychoeducation, goals.

Psychoeducation Plan for David

- Responsibility for Sexual Behavior
  - Module 2: Sexual Behavior & Sexual Abuse
  - Review the range of sexually assaultive and offensive behaviors, such as hands-off sexual misconduct including sexual harassment, stalking, unwanted sexual gestures, etc. etc
  - Discuss how healthy, mutual, and respectful sexual behaviors, between consenting individuals.
  - Differentiate healthy sexual behavior from assaultive and offensive sexual behavior and introduce the concept of consent (e.g., able to freely agree and disagree).
  - Student discussion Session with Dr. Abrams: Consent Part I, II, III and IV, legal definitions of sexual assault, legal definitions of consent, sexual assault and the law
  - Experiential Exercise: Amount of Sexual Assault
  - PP handouts: sex and the law
  - CERTS model

Psychoeducation Plan for David

- Responsibility for Sexual Behavior
  - Module 3: Focus on Socialization & Sexualization in Society
  - Review negative group psychological influences that may contribute to a "rape culture", (i.e., the shared belief that rape is prevalent and sexual violence is normal, acceptable, and excusable). In other words, peers validate, condone, or approve coercive sex. Further, some peer groups encourage sexual competition; such as when sexual conquests are seen as a way for a male to prove he is a "real man". Sometimes, some peers consider sexual abuse appropriate payback for perceived slights or wrongdoing (e.g., turning down a request for a date).
  - Student discussion session with Dr. Abrams: Accountability, Pressure to have sex, sexual assault statistics and definition videos, facts about sexual assault
  - Modules 4, 7, 8

Psychoeducation Plan for David

- Attitudes/Beliefs about Sexual Misconduct
  - Modules 2, 3, 5
  - Student discussion session with Dr. Abrams: Hostile Masculinity Healthy Masculinity
- Victim Impact/Empathy
  - Module 6
  - Activities to illustrate consequences of sexual abuse
  - Student discussion session with Dr. Abrams: Report sexual assault, impact of sexual assault, consequences of sexual assault, who is impacted by sexual assault, victim blaming, consequences of reporting sexual assault, part I and II

Psychoeducation Plan for David

***Bold denotes significant need**

- **Peers –Relationships/Pressure**
  - Module 3 – Discuss peers and how they influence the student. Help student identify negative peer influences; discuss positive and negative peer pressure; discuss groupthink
  - Herding PP
  - Module 5 – discuss what it means to be a "man" and what it means to be "masculine". Name some famous people that are really masculine; discuss attitudes about relationships and sex – how much is influenced by peers.
  - Module 7
  - Module 8 – Friends and Partners. Brainstorm attributes of healthy relationships; what is healthy; what is unhealthy; discuss whether various behavioral examples are signs of caring and healthy relationships.

Psychoeducation Plan for David

***Bold denotes significant need**

- Healthy Intimate Relationships
  - Module 8: Developing healthy relationships
  - (5) Encourage the student to brainstorm attributes of healthy relationships (e.g., trust, compassion, respect) and unhealthy relationships (e.g., jealousy, distrust, coercion). Discuss whether various behavioral examples are signs of caring and healthy relationships (e.g., advising which clothes are acceptable to wear, reading the other person's text messages, insisting on sharing of passwords to social media, disallowing hanging out with other people, etc.). What is a healthy versus unhealthy relationship?
  - Student discussion session with Dr. Abrams: Communication Part I & II, Confirming consent , Sexual satisfaction , Consent Part I, II, III, and IV (also can use in Module 2)

Psychoeducation Plan for David

***Bold denotes significant need**

- **Mentors or Other Pro-Social Supports**
  - Module 8
  - Discuss healthy relationships. Ask the student to identify the key components of healthy relationships.
- **Other: Communication/consent**
  - Module 8 – communicating effectively. Discussion the importance of different types of communication (verbal, body language).
  - Discuss how communication can be hinder by emotions and intoxication.
  - Discuss and practice active listening skills
  - Dr. Abrams videos: Confirming consent, Communication I and II

SECTION VII

Getting Started and Reminders

- All pilot participants using any of the STARRSA tools should have
  - Attended a training by the STARRSA team
  - Signed a confidentiality agreement
  - Be confirmed by the STARRSA team that they are on the DOJ privacy certificate
  - Receive a copy of the Information sheet from the point person/lead contact at your college/university for this program implementation
- Please read the manuals and all materials
- Consult with the team if you have any questions at any team about the products and materials
- Consult with the team for implementation and clinical questions (no name or student identity may be shared, but clinical information to obtain consultation can be offered)
- Please be aware of federal/state laws and university policy and guidelines with respect to
  - Suicidal and homicidal ideation
  - Mandated reporter obligations
  - University reporting obligations
  - Emergency and safety policy and procedures
  - Understand how these will be communicated to the student and handled should they arise during the pilot implementation
- Prepare informed consent (STARRSA CBT Treatment) and agreement forms (STARRSA Active Psychoeducation). All students, regardless of program must be given either a consent or agreement form. See samples included in program materials
- Outside clinicians should have discussion about referrals and what information might be requested prior to starting treatment.

APPENDIX B

Student Identity and Diversity

CLIENT DIVERSITY AND CLINICAL CONSIDERATIONS

The STARRSA Project deals with college students, typically in the age range of 18 to 25, who have been found responsible by their academic institution for perpetrating sexual misconduct. Although predominantly composed of heterosexual men who have harmed female victims, this unique subgroup of the student population contains students from a broad range of backgrounds. STARRSA was designed to accommodate the needs of all students who sexually offend, integrating various social group identities into the STARRSA language and clinical protocol. This Appendix discusses client diversity and addresses instances in which clinical approaches benefit from modification to fully address individualized client needs.

Considering the Layers of Social Group and Personal Identities within Clients

Students come from a range of backgrounds, cultures, and identities. The STARRSA Program is intended to be inclusive of, and used with, all students, across the range of social group and personal identities present among those who engage in sexual misconduct. Although most of the materials are framed for use with heterosexual males because they constitute the majority of known perpetrators of campus sexual misconduct, the materials may be adapted for use with students from various races, religions, sexes, gender identities, and sexual orientations, as well as for those who identify with a chosen campus group (e.g. a fraternity or athletic team) that may be relevant to treatment.

By using an RNR (Risk-Needs-Responsivity) framework, the provider can take empirically derived risk and treatment factors and apply them to an individual. This program emphasizes a tailored, individualized approach that recognizes consideration of misconduct-relevant identities as well as the social and interpersonal dynamics and unique situational dynamics (e.g., partying) common to most college students. We recommend that providers consider, as part of individualization, social and personal identities that may be relevant to the presenting misconduct, as these identities can impact the student's opinion of self, others, and their world view. Identity can include racial and ethnic background, immigration status, gender, sexual orientation, religious affiliation, as well as certain voluntary peer and group affiliations. We encourage providers to explore during the initial assessment and throughout treatment, the misconduct-related meaning that a particular identity may have for a student. Identities range on a continuum from fluid to crystalized, and these "meanings" may or may not be relevant to the misconduct and thus to treatment. Additionally, there may also be intra-individual variation in flexibility across different identities (e.g., a student may have a crystallized political identity, but a fluid gender identity). An individual's identify is not made up of solely one facet, and each facet may develop over time, through different contexts. It is critical to explore with the student

these various facets of their identity and their intersection (e.g., age, gender, ethnicity, race, immigration status, social class, religion, sexual orientation, disability). For a detailed discussion please see, http://www.apa.org/about/policy/multicultural-guidelines.PDF.

Why identity matters in treatment

Understanding a student's unique identities, and how these interact with risk-needs factors will help enhance rapport, improve assessment and treatment planning, and ultimately improve outcome effectiveness. More importantly, the ability of a clinician to understand and convey genuine interest in learning and exploring a student's identity will help facilitate trust and build therapeutic rapport. Although the focus of treatment is not identity exploration, but rather to target the risk-need factors related to sexual misconduct, exploring a student's intersectional identities (e.g., racial, gender, sexual orientation, socioeconomic status; See Crenshaw, 19891), particularly at this emerging stage of development, can be a powerful tool in enhancing engagement and commitment to therapy. By helping a student identify the components of their "ideal" or "best" self, a clinician can, in turn, help the student identify areas that need to change or improve in the course of therapy, and identify specific attitudes and behaviors that they want to change in order to be more congruent with their "best" self, or at the very least, consistent with non-harmful, prosocial interactions. A provider working with a student who is struggling with issues related to their identity, or has faced discrimination or harassment due to their identity, may need to consider referring that student for adjunctive or specific treatment services. Students grappling with and navigating challenges associated with identity may be at increased risk of harm to self or others. If a provider is working with a student who is being threatened or harassed or was the target of a hate crime, appropriate actions should be taken as dictated by federal/state laws and university requirements.

Social and personal identities do not develop in a vacuum but are interactive and highly influenced by family and peers. College students are, by developmental definition, peer-focused. In the section below, we discuss specific social group identities relevant to college students and underscore that our discussion is not intended to be comprehensive. We have included relevant peer groups and organizations that are normative for this age and most commonly represented on college campuses.

A student may identify with multiple groups from this list and within each category there may be "variations" or "subcategories" unique to that student. We want to reiterate that this appendix serves two functions. First, it provides a basic overview of different social group and personal identities that may be relevant to the student to help the clinician appreciate what to consider to develop rapport and understanding. Second, we have tried to outline key issues that are important to consider when working with a student who identifies with a particular social group and/or personal identity.

We want to be crystal clear that there is no known or implied association of any particular identity with sexual misconduct. To the best of our knowledge, there is no literature, empirical or otherwise, that directly or indirectly associates a personal, social, sexual, racial or ethnic identity with sexual misconduct. Research that implies or infers an association with a particular social group, such as fraternities, is targeting risk factors that

co-occur with social group activities, such as alcohol and parties.

The singular goal, in providing this section, is to help educate providers, be they therapists or facilitators, with regard to potentially relevant identity-related issues. For each social group identity, we:

1) Provide a brief overview of that identity to enhance a clinician's competence when working with individuals who identify with that group. This program does not provide a comprehensive training, just a basic foundation. We recommend that providers seek additional information and consultation about a particular identity or intersectional identity (e.g., Black, White & male, immigrant, Asian-American, Hispanic, gay, female & lesbian cisgender, etc.) if it appears that the identity may be treatment-relevant and if the provider has limited knowledge and/or experience working with that identity.

2) Present key issues, challenges and concerns often expressed by members of this group. This does not mean that students who are members of that group will all have the same concerns, only that they are more commonly reported concerns and should be considered. This includes suggestions for clinicians/facilitators to help enhance rapport. Rapport is vital. If the provider fails to fully recognize, acknowledge and accept the student for who he/she is, it is likely to undermine the effectiveness of any intervention.

3) When relevant, a summary of the literature in the context of sexual misconduct.

CAUTIONARY NOTE: We want to provide some cautionary points about social group identities. Although we encourage providers to explore and consider the different facets of a student's identity, it is all too easy to become overly focused on that identity and lose sight of the goal of treatment – addressing the student's sexual misconduct. A danger of classifying a student by his or her identity is that it can divert the focus to issues unrelated to the misconduct. Thus, exploring identity can be critical for some students as it relates to their misconduct, and unrelated or irrelevant for other students. As stated above, however, clearly acknowledging and accepting the client's identity is essential for establishing trust. As just one example, the rate of failure to return to session is especially low for clients of color, and it seems to be related to provider's failure or inability to fully and properly acknowledge the clients' cultural / racial identity. Given the bleak history of how students of color have been treated with regard to allegations of sexual misconduct, the need for establishing rapport by acknowledging head-on issues or concerns potentially related to racial and / or ethnic identity.

RACE AND ETHNICITY

With respect to identity, race and ethnicity can be quite relevant and meaningful. Providers should entertain the possibility that a student's racial and / or ethnic identification, including a history of marginalization and discrimination both prior to college and during college, may be a factor that must be addressed. Incidents in which the student felt alienated, rejected, or worse – treated with outright hostility - may be related to their

race or ethnicity, and in turn such experiences may have contributed to their misconduct. Moreover, how these experiences were responded to by the campus administration and their representatives, as well as the student's ability to obtain and use campus services and resources, may be relevant. Thus, if you are a provider working on campus for the school, these negative experiences may impact, at least initially, the student's response to you and to treatment, possibly necessitating more work at the beginning to establish trust and rapport.

There are no data suggesting that members of any particular racial or ethnic group (Caucasians, Hispanics, Latinos, Asians, or African-Americans) are more likely than others to engage in sexual misconduct. The only differentiator is gender: the vast majority of complaints are against men and the vast majority of complainants are women. Male sexual misconduct appears to involve a similar set of confluent risk factors; the same or similar risk factors are noted in all of the above mentioned racial and ethnic groups. These risk factors include negative masculinity, impersonal sex, immature social skills and misperception of women's sexual cues, adherence to rape-myths, high-risk alcohol use, peer pressure, and coercion-supporting peer groups.

Why include race and ethnicity in a discussion regarding client diversity?

Race in particular has a particularly grim, cruel history in the United States, evidenced tragically in all matters pertaining to sexuality. Moreover, the assumed linkage between race and crime has deep historical roots in this country. It is a history that lives in the present and cannot simply be ignored when beginning to develop a client–provider relationship. The point, once again, is simply to give space, time, and permission to address any race or ethnicity-related issues that the client may wish to in order to facilitate rapport. Secondly, fundamental to the principle of responsivity, clients of different racial and ethnic backgrounds may view therapeutic interventions differently and respond differently; the goal of the provider is to understand how the client will respond the best (for a detailed review see Thomas, Solórzano, & Cobb, 2007).

In summary, providers must entertain the possibility that a student's racial and/or ethnic identification, including a history of marginalization and discrimination both prior to college and during college, may be a factor that must be addressed. Incidents in which the student was subjected to bias or hate-related incidents or micro-aggression based on their race or ethnicity on campus may be particularly salient if the client is being seen on campus. In such cases, providers may want to consider how these experiences were responded to by the campus administration and how the responses, or lack thereof, might impact the student's ability to utilize campus counseling services. If you are a provider working on campus for the school, those negative experiences may impact, at least initially, the student's response to you, possibly necessitating more work at the beginning to establish trust and rapport.
(See: http://www.apa.org/about/policy/multicultural-guidelines.PDF)

Studies that address some of these issues focus on demographic characteristics of students voluntarily seeking counseling on campus, not students found responsible for sexual misconduct and mandated to various remediation programs. With this important difference in mind, we can offer a few examples. Although one study found that European-American students were more likely to have used mental health treatment

services over a 12-month period than any other student group (Hermann et al., 2011), another study found that there were no differences in how Asian, African-American, Latino/Hispanic, and Caucasian students utilized counseling services (Rosenthal & Wilson, 2008). African-American students reporting negative family attitudes about mental health treatment were, not surprisingly, less likely to seek help for psychological problems (Barksdale & Molock, 2009). Similarly, greater mental health stigma and the tendency to withhold embarrassing personal information were linked to a reduced likelihood of seeking help among African-American students (mostly women) (Masuda, Anderson, & Edmonds, 2012). Although African-American students reported less emotional distress than Asian and White Students, there was no difference between groups with respect to academic distress (Soet & Sevig, 2010). Research has found that cultural norms regarding male dominance play a role in increasing sexual harassment (de Hass & Timmerman, 2010). In addition, Baron and Stratus (1989) discuss male gender roles, culture norms that approve of violence, and patterns of male dominance related to sexual misconduct.

RELIGIOUS AFFILIATION

Religions typically espouse beliefs that purport to include a moral code dictating practices and behaviors deemed virtuous. The three major Western religions, in particular, each provide a bedrock for what not only is deemed "virtuous" but imperative for its adherents. For adherents, however, religion may proscribe values and beliefs in the form of "imperatives" that conflict with other identities that they may hold (the most obvious examples being non-binary or having same-gender sexual interest). It may be important to a student to explore the intersection – and conflicts – between their religious faith and their identity. Once again, the rationale for doing so would be a judgment that these conflicts may be related to their sexual misconduct.

Many campuses in the United States have clergy representing only the three major Western religions. Clearly, this represents but a small fraction of the religious denominations throughout the world, and, by extension, not all students on many campuses in the United States. Although most international students still come from Europe, and thus more likely to identify with one of the three major Western religions, an increasing percentage of international students are coming from Latin America, Asia, Africa, the Middle East, and Oceania. If a student belongs to a denomination for which there is no campus representation (clergy or student groups / clubs) and she or he is a devout adherent, this may lead to isolation, a sense of separatism. International students may gravitate to campuses in the U.S. with the expectation of pluralism and find themselves segregated and attached only to a handful of students from the same country. Students that express their adherence in visible ways that draw unwanted attention (e.g., Muslim women that wear a burqa, a chador, a niqab, a hijab, or a khimar (headscarf) or the turban traditionally worn by Sikhs) may find themselves the victim of harassment and verbal abuse or hazing and even assault. Alternatively, if a student adheres to a religious faith that occupies a privileged status on campus, this could be relevant to any perception of impunity the student may have regarding their actions or behavior. In addition, belief systems tied to religious faith may have bearing on the nature of treatment, especially if those beliefs are not consistent with therapeutic aims.

To our knowledge there are no studies that look at religious affiliation or practice of students found responsible

for sexual misconduct. Nor have studies looked at how religious beliefs or practices impact attitudes and beliefs about sexual misconduct. Nevertheless, it may be important for providers to consider ways in which a student's religious affiliation could be relevant to the misconduct. Barnett (2016) reviewed the role of religion and spiritualty in psychotherapy and how individuals can ethically and competently provide individuals with efficacious treatment.

Barnett, J. E. (2016). Are religion and spirituality of relevance in psychotherapy?. Spirituality In Clinical Practice, 3(1), 5-9. doi:10.1037/scp0000093

WOMEN AND SEXUAL MISCONDUCT PERPETRATION

Overall, there has been very little empirical research on adjudicated female sexual offenders, and none on female college students who engaged in sexual misconduct. Few research studies provide information about sexual misconduct or abuse by females, in large part because they are relatively few in number. Prevalence studies using community samples indicate approximately 3% of forcible rape arrests in the United States in 2015 and 8% of other coercive sexual offense arrests involved women (Uniform Crime Reports, 2015). Even less is known about incidence rates of college women who engage in sexual misconduct. In a Turkish study of 1,376 college students, including 886 women, 28.9% men reported at least one instance of sexual perpetration, while 14.2% of the female students acknowledged sexually abusive behavior (Schuster, Krahé, & Toplu-Demirtaş 2016. A similar pattern was found in a survey of first-year college students from multiple universities in Germany, where nearly twice as many college men (13.2%) reported engaging in sexual misconduct as women (7.6%) (Krahé & Berger, 2013). How representative these studies are of other countries is unknown. Nor, of course, is there any uniformity in how "sexual misconduct" is defined across studies. Similar to men who sexually abuse, sexual misconduct by women apparently includes a range of sexual behaviors, including harassment, unwanted touching and fondling, digital penetration and penetration with an object. Sexual misconduct by female college students involving their peers suggests it is less frequent than female sexual abuse of children or non-peer adolescents. Nevertheless, the incidence rates reporting by the Turkish and German studies are striking for their relatively high rates of self-disclosed abuse. For those interested, Cortoni (2014) provided a detailed literature review of female sexual offending.

The limited information on female college students may well reflect a greater degree of underreporting of such abuse on campus. Moreover, since women, unlike men, are less frequently prosecuted, the assessment of risk factors and development of treatment targets has not been a focus of clinical or research attention.

Overall, sexual abuse by women is considered to be significantly underestimated. There are a variety of explanations as to why this is the case. As Williams & Briere (2015) observed, reports of sexual offenses are substantially under-reported in general and abuse by females may be especially underestimated as many victims may have pronounced feelings of stigma due to having been sexually abused by a woman. Further, it is felt that the criminal justice system and related professionals discount sexual abuse by women, considering it to be less "significant" – less a crime – than sexual abuse by men, and, when recognized, females may be

treated more leniently than their male counterparts. Further, many of the known sexual offenses involving adult women are with juvenile male victims. In these, predominantly unreported, statutory offenses, the juvenile victim wears his sexual "liaison" with the adult woman as a "badge of honor," coming into manhood as it were. Yet, females and males that are the targets of sexual misconduct by females can and occasionally do experience significant trauma as a result of the victimization. Social perceptions of females have important influence of victim reporting practices and attitudes of women as potential sexual aggressors. Women have been historically identified as passive, compliant, and harmless, and this innocuous portrayal has led to an added complexity of disclosing sexual abuse by females (Denov, 2003; Donnelly, Kenyon; 1996)

The literature does suggest some important findings relevant to assessing and treating women who engage in sexual misconduct (e.g., Cortoni, 2014; Gillespie, Williams, Elliot, Eldridge, Ashfield, & Beech, 2015). For example, although many men who offend sexually have experienced some degree of childhood maltreatment and / or family adversity, such experiences are even more common in females who sexually abuse others, especially sexual abuse during childhood (Levenson, Willis, & Prescott, 2015). In a study of women who were victims and perpetrators of intimate partner violence, women who were both the victim and perpetrator of intimate partner violence had higher rates of perpetration and victimization than women in perpetrator-only and victim-only groups. Among the women who were both victims and perpetrators, there was a similar degree of reciprocity with respect to the severity of violence and the occurrence of injury (Orcutt, Garcia, & Pickett, 2005). Further, female college students in relationships that are characterized by "infatuation, obsessive or addictive love," are more likely to be both the victim and perpetrator of violence within their relationship (Charkow & Nelson, 2000, p. 18). The risk of violence increases with the seriousness and the length of time of the relationship. However, protective factors against dating violence include relationship dynamics, such as empathy and intimacy (Murray & Kardatzke, 2007). Such early life experiences may have current relevance as they contribute to attitudes and beliefs that justify sexual misconduct. These early adverse events also may influence negative peer associations and dysfunctional relationship choices, making it more difficult to form trusting relationships with others, including professionals whose job it is to help clients make healthier life choices.

Although less is known about women who engage in sexual misconduct than men who sexually abuse, women are more likely to co-offend than men. Research suggests that between a third and a half of women who sexually offend have co-offenders (DeCou, Cole, Rouland, Kaplan, & Lynch, 2015; Williams & Briere, 2015). The co-offenders frequently are romantic partners who may be physically or emotionally abusive. These women may engage in sexual misconduct due to fear for their physical or emotional safety. They may engage in sexual abuse due to abandonment fears or to please their partners. In some cases, the sexual abuse may be the woman's idea, and she may instigate the offense. Additionally, some women engage in sexual abuse on their own. Solo offending may be motivated by a variety of emotions, such as loneliness and interpersonal difficulties, wherein the women sexually offend as a way to achieve intimacy and sexual gratification (DeCou, et al., 2015). Feelings of jealousy and anger, desires for dominance or revenge, perhaps related to real or perceived wrongdoing or infidelities, are other possible motivating factors. Thus, compared with men, attachment difficulties and dependency problems may be more predominant risk factors for women. Similar to men who sexually offend, women who engage in sexual offenses often have offense-justifying cognitions (e.g.,

DeCou et al., 2015; Gannon et al., 2008, 2013; Cortoni, 2014). Some of their erroneous beliefs and attitudes may be gender specific, such as thinking that sexual abuse by women is less harmful than abuse by men or that a man's perceived needs should come before a woman's. They also may harbor abuse fantasies that may need to be addressed in treatment. Additionally, some women, like men, may have an antisocial orientation. In these instances, assessment and treatment may need to address risk and protective factors related to general criminal offending (e.g., Andrews & Bonta, 2010). In sum, women who engage in sexual misconduct may have a range of possible motives and offense-justifying cognitions and emotions that warrant assessment and possible intervention. In addition, there is some evidence that, compared with men, substance abuse may be more of a contributing factor for women who initiate sexual misconduct, particularly when offenses are impulsive (Gannon et al., 2008, 2013 as described in Cortoni, 2014).

As Cortoni (2014) has noted, available research indicates the sexual recidivism rates for women who have been adjudicated for a sexual offense are exceedingly low, with some larger studies suggesting re-offense rates of less than 2 percent (e.g., Sandler and Freeman, 2009). Due to this exceptionally low rate it has not been possible to identify empirically validated risk factors that are associated with an increased risk of repeat sexual offending. Typically, women, like men, who sexually abuse are more likely to reoffend with a nonsexual offense, if they reoffend at all. Research indicating whether this is also true for college women who engage in sexual misconduct is lacking.

In sum, empirically validated risk and protective factors associated with sexual recidivism risk have not been identified for women. Given the low frequency of sexual reoffending by women and the apparent heterogeneity among women who engage in sexual misconduct, identifying such risk factors will continue to be very difficult. Available research has identified some factors that contribute to the occurrence of female sexual misconduct and indicate that, similar to males, relevant factors include cognitions that support sexual abuse, relationship difficulties and problems in psychosocial functioning, emotion and general self-regulation challenges, and occasionally ongoing abuse fantasies. Gender specific nuances pertaining to these factors, however, may be present and must be addressed (Cortoni, 2014). As reflected above, early adverse life experiences, childhood maltreatment, partner abuse, and persistent mental health challenges may contribute to strong dependency needs, attachment difficulties, and significant interpersonal problems in women who engage in sexual misconduct, all of which may require attention. Helping these women develop a healthy sense of independence while cultivating positive relationships and social networks is essential.

Please see Guidelines for Psychological Practice With Girls and Women. (2007). American Psychologist, 62, 949-979. doi:10.1037/0003-066X.62.9.949

GENDER AND SEXUAL ORIENTATION

We have devoted a greater amount of attention to discussing Gender and Sexual Orientation, since, relative to other expressions of student diversity, misconduct is highly under-reported and yet appears to be a growing problem; due to under-reporting, there is also a dearth of research. Feedback from many campuses that we

visited underscored the critical importance of a focus on harassment and assault of non-binary students, as well as misconduct committed by non-binary students.
Traditionally, the constructs of “sex” and “gender” have been used interchangeably, albeit with fundamental conceptual differences (Davis, 2009). Whereas sex broadly refers to biological differences between males and females (i.e., genitalia and hormones), gender refers to the role each sex (“men” and “women”) plays in society and culture (WHO, 2017). Different from sex, which is mostly genetically determined, gender is shaped by societal expectations (gender role) and the individual's self-concept (gender identity). In line with the traditional view, gender has largely been defined in binary terms based on the two biological sexes - male and female (Davis, 2009). However, recent developments have challenged this definition. Gender roles and stereotypes are fluid and can shift over time depending on societal and cultural changes.

The terms below differentiate between sexuality, sexual orientation, gender identity / sex/gender assigned at birth, and gender identity / biological sex (i.e., the sex assigned at birth). Each of these aspects of sexuality constitute a continuum. Present thinking is that individuals do not exercise choice where they fall along the continuum. Although students should be asked where they feel they fall on these continua at the present time, these “identities” may change during the course of treatment. It is important to note that these identities are independent of one another.

Sexuality is an umbrella term referring to three parts of an individual's life experience. The three parts are orientation, behavior, and identity. First, orientation refers to who someone is attracted to. Second, behavior refers to who someone is sexually active with (usually broken down by gender in U.S. society), and third, identity refers to the terms that an individual use to understand and communicate his or her orientation and/or behavior. These three descriptors (i.e., orientation, behavior and identity) are fairly complex in how they interact, and for some they change over time:

> **Example 1:** Lisa is attracted primarily to women (orientation); she is currently and previously only been sexually active with women (behavior), and she refers to herself as lesbian (identity).
>
> **Example 2:** Jesse is attracted to people of all genders (orientation); he is sexually active with people of all genders (behavior), but only has ongoing relationships with women (behavior), and he refers to himself as straight (identity).

Gender (sex assigned at birth) is based on one's genetic makeup, genitalia, and sex organs (penis, vagina, testes, ovaries). When we are born, doctors and/or midwives look at our genitals and make an assignment based on what is observed. Sometimes they are uncertain as to which of the two legal (i.e., female or male) assignments to make, resorting to the term “ambiguous genitalia.” These individuals may refer to themselves as intersex (see below). Some people find that their gender assigned at birth is consistent with their understanding of their gender (i.e., cisgender), and others do not (i.e., transgender or gender non-conforming).

Cisgender is the term used for an individual whose self-identity conforms with the gender that corresponds to their biological sex (or sex assigned at birth), not transgender.

Gender identity is an internal sense of self in regards to gender: emotionally, cognitively, and socially. Socially typically is described in binary terms (male or female), but historically it has been more fluid or non-binary (e.g., Feinberg, 1996; Kosman, 2007; www.Transtorah.org). We all have an internal sense of gender, or lack thereof, so these distinctions become important for any client.

Gender nonconformity typically refers to individuals whose external gender expression differs from the cultural expectations based on their sex assignment at birth, using the gender identity label associated with their assigned birth sex or another diverse gender identity label (Katz-Wise, Reisner, White, & Keo-Meier, 2016, p. 2). Gender fluidity "implies an escape from the constraints of gender assumptions and a refusal to stay within one category or another," (Davis, 2009, p. 101).

Sexual orientation is not chosen. Research indicates that sexual orientation is biological. Sexual orientation most commonly refers to which gender or genders that an individual is primarily physically, romantically, and sexually attracted to. In terms of gender, sexual orientation can also be related to a more specific gender attraction when the individual identifies a trait s/he is interested in, such as masculinity, femininity, androgyny, etc. The bottom line is that sexual orientation relates to some physical, romantic, or sexual attraction.

THE LGBTQ ACRONYM

The letters LGBTQ (and possibly I and A) are grouped together purposefully. Even though each letter represents something different, when the acronym is considered together there is a perceived "power in numbers." This perception may help enhance a client's sense of belonging and also facilitate increased acceptance of individuals and the LGBTQ community while helping affect positive political and social change.

LGBTQ is an acronym that is defined for the purpose of this program as follows:

L (Lesbian):

A woman who is sexually attracted to women. Lesbians may be transgender.

G (Gay):

A man who is sexually attracted to men. Gay men may be transgender.

B (Bisexual):

An individual who identifies as being attracted to having sexual, romantic, or physical engagements with any gender identity; bisexual individuals may also be transgender.

T (Transgender):

Unlike the LG&B terms that reference sexual attraction, transgender refers to gender. This term refers to

individuals whose sense of self does not match their assigned gender/sex at birth. Transgender refers to someone who does not feel like they fit in a male or female category; they might believe that they are the wrong gender, but they might not desire surgical or hormonal reassignment (Meier & Labuski, 2013). Transgender individuals might fall anywhere along the gender spectrum, which is a "non-binarized and three-dimensional palette of gender and sex expression" (Meier & Labuski, 2013, p. 291). Transgender can include people such as transsexuals, transvestites, cross-genders, gender-nonconforming individuals, masculine females, and feminine males (Bilodeau & Renn, 2005; Meier & Labuski, 2013). According to Dugan, Kusel, and Simounet (2012), it is difficult to estimate how many transgendered students there are, since transgendered is often not a response option on surveys. Further, prevalence estimates are difficult because there are inconsistencies in how transsexual and transgender are defined by researchers in different studies (Meier & Labuski, 2013). However, in a national sample of students, 479 out of 289,024 students (0.17%) identified as transgendered (Diemer, Grant, Munn-Chernoff, Patterson, & Duncan, 2015). The estimated prevalence of transgendered individuals in the United States is approximately 0.48%, as per a survey conducted in Massachusetts (Meier & Labuski, 2013).

Q (Queer or Questioning)

- **Queer** - a sociopolitical term reclaimed (after being used pejoratively beginning in the early 19th century) in the 1980's by scholars studying sexuality and gay politics (cf. Oxford English Dictionary, 2014). Some use queer as a part of their refutation of an assumed heterosexual/hierarchical political identity. One might use this term as an identity when they are unsure or feel as if they do not fit properly into one specific group. Others use the term queer because their sexual attraction includes people who do not exist on the simple binary spectrum of male or female, so the term "bisexual" is not appropriate.
- **Questioning** - refers to individuals that are exploring (internally or externally) their sexual or gender identity. As the name suggests, they are questioning in which group (or groups) they may belong.

In addition to the above acronym, "I" is occasionally included at the end:

I (Intersex)

Intersex- there are over 500 intersex conditions. "Intersex" is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. Intersex is not a sexual orientation, nor is it a gender identity. Intersex is an identifier originating from the medical community.

Sometimes there is also an "A" associated with this acronym (Asexual or "Ace").

OTHER KEY SEXUALITY TERMS AND ISSUES

- **Homophobia** (fear or hatred of people assumed to be LGBT and anything connected to their culture). It can also be a response to fearing homosexuality within oneself.
- **Heterosexism** (a bias towards heterosexuality or the exclusion of anything LGBTQ),

- **Internalized Homonegativity** (negative feelings towards oneself since one is not acting like the social expectations of being heterosexual),
- **Internalized Homophobia and Internalized Heterosexism** (one's internal feelings regarding fear or bias, respectively).

It is very important to remember that until quite recently, and still in many places, LGBTQ individuals were considered akin to, or even likely to be, pedophiles. Because such harmful stereotypes may be internalized as truths about oneself, it may be critical to identify and label the stereotype as a myth for your client, thereby helping them to begin to separate their behavior from their sexual and/or gender identity.

LGBTQ: IDENTIFICATION & SEXUAL MISCONDUCT PERPETRATION.

As noted above, the vast majority of sexual violence is perpetrated by heterosexual men who sexually assault women. Although recent studies report high rates of sexual victimization among individuals who identify as LGBTQ (Cramer, McNiel, Holley, Shumway & Boccellari, 2012), until quite recently LGBTQ individuals have not been a part of systematic research on sexual perpetration. Because research on sexual perpetration has almost always focused on heterosexual men, we have very limited knowledge about sexual misconduct among the LGBTQ. Consequently, very little has been written about sexual violence in the LGBTQ community, and even less about sexual violence among Transgender individuals. As research in this area evolves, and as LGBTQ individuals are offered treatment options, we are likely to see more accurate estimates of incidence.

There is, however, more literature and data on the occurrence of dating violence/partner abuse in LGBTQ communities, and that violence sometimes includes sexual aggression. Generally, gay, lesbian, bisexual, and students of other sexual orientations in fact appear to be at high risk for sexual abuse and rape (Porter & Williams, 2011). Gay and bisexual men report experiencing sexual assault at rates similar to those of heterosexual females (Ford & Soto-Marquez, 2016). Further, gay men and bisexual men and women were more likely to report sexual victimization than heterosexuals (Johnson, Matthews, & Nappier, 2016). Lesbian and bisexual students are also more likely than their heterosexual counterparts to report some form of harassment (Cortina, Swan, Fitzgerald, & Waldo, 1998). More specifically, LGBT students report higher rates of sexual harassment and contact sexual harassment than non-LGBTQ students (Perez & Hussey, 2014). Compared to heterosexual students, sexual minority students report more physical dating violence, sexual assault, and unwanted pursuit – stalking & pressure (Edwards et al., 2015). With respect to rates of sexual assault, one study found that two out of five bisexual female college students reported experiencing sexual assault while in college (Ford & Soto-Marquez, 2016). Another study found that approximately 63% of "GLB" participants reported experiencing some form of sexual assault, and almost 40% reported sexual re-victimization. Gay men and bisexual men and women were more likely to report sexual re-victimization than lesbians (Heidt, Marx, & Gold, 2005). With regard to intimate partner violence among LGBTQ students, sexual perpetration was related to internalized homo-negativity (Edwards & Sylaska, 2013).

Further, LGBTQ survivors of sexual assault have to cope with both the aftermath of their experience as well

as the discrimination they face due to their sexual orientation or gender identity (Perez & Hussey, 2014). Richardson, Armstrong, Hines, and Palm Reed (2015) found that LGBTQ students and heterosexual students experienced similar rates of forced sexual contact and forced sexual intercourse, but the LGBTQ students were more likely to be the victim of threatened sexual intercourse, sexual contact when they are too intoxicated to consent, sexual violence when substance use was involved, and were more likely to be physically injured during the assault. Victim and perpetrator substance use was a risk factor for both LGBQ and heterosexual victims.

Reed, Pardo, Masumoto, and Amaro (2010) found that "GLB" students reported feeling less safe on campus, experienced increased stress levels, and had more experiences of threats and victimization compared to their heterosexual peers. These factors resulted in "GLB" students engaging in more alcohol and drug use than their peers. Alcohol is a major risk factor for sexual assault and dating violence among sexual minority students (Hequembourg, Parks, Collins, & Hughes, 2015; Ollen, Ameral, Palm Reed, & Hines, 2017). Transgendered individuals were more likely to experience alcohol-related sexual assault than non-transgendered individuals (Coulter et al., 2015). Compared to heterosexual women, lesbian and bisexual women were more likely to report negative drug and alcohol related experiences, such as having unplanned sex after drinking (Esteban McCabe, Boyd, Hughes, & d'Arcy, 2003). Another study, however, found that sexual assault was associated with alcohol abuse in heterosexual women but not in lesbians (Hughes, Johnson, & Wilsnack, 2001).

LGBTQ students also face more barriers to seeking help than their heterosexual peers. Such barriers to help after dating violence and sexual assault among sexual minority students include fear of further marginalization, concerns about injuring the reputation of the community, fear of being "outed," as well as concerns similar to those of heterosexual students, such as feelings of embarrassment and shame (Ollen, Ameral, Palm Reed, & Hines, 2017). Perez and Hussey (2014) noted that colleges and universities may not provide competent treatment for LGBTQ sexual assault survivors; the treatment provider may ask inappropriate questions or may not have the necessary knowledge, training, or experience regarding the dynamics of sexual violence when the perpetrator and victim are the same gender. Richardson and colleagues (2015) noted that both LGBTQ and heterosexual students were reluctant to seek help because they did not believe that the incident was serious enough to report, but LGBTQ students were more likely to report that they did not seek help because they believed they would be blamed for the incident.

Clinical Considerations

On occasion, students referred for treatment due to sexual misconduct may identify as LGBTQ or I, as defined above, or may have confusion about their sexual orientation or gender identity. The following overview is presented to provide basic information for a clinician who may have limited or no experience working with these clients. Depending on the client, the presenting concerns, risk and protective factors, and treatment needs will vary. Every clinician must be mindful of his or her areas of professional competence, practice within these areas and refer clients when appropriate. For example, if a clinician has limited experience with clients who are questioning their sexual orientation and gender identity, and the client's identity confusion is a risk relevant treatment need, a referral to someone well-experienced in this domain is likely appropriate. In contrast, if sexual orientation or gender identity concerns are not a significant concern for the client or strongly related to the sexual

misconduct, the same clinician may be able to provide treatment effectively, and seek appropriate consultation if needed.

When working with the LGBTQ population, like with any marginalized group, language is critical. There are several key points to consider when encountering a client identifying as LGBTQ. First and foremost, do not make assumptions about the client. At the outset, it is important to clarify with the client how they wish to be referred to (e.g., name, gender, etc.). For example, "I see that you wrote your name as Tammy on the form; is this the preferred name you wish to be called," or, "Do you use a preferred pronoun that I can also use when speaking with you?" It is important to allow clients to define themselves. For example, they may define themselves as non-binary or non-conforming. They may request that you use different pronouns than you are accustomed to (e.g., ze/hir/hirs or they/them as personal pronouns). Ask your clients what pronouns they would like you to use, and be prepared to provide the pronouns you use for yourself as well. It is also important to avoid using terms such as "marriage" or "boyfriend / girlfriend." Rather, ask about "partners," and if the relationship is "romantic." For example, "Do you have an identified romantic interest," or, "In your romantic relationship, do you practice exclusively, or are you open to other romantic/sexual partners?"

Further, the identities associated with being Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning (LGTBQ) are fluid, meaning that they are subject to change. Hence, the client may well present as confused. Be sure to explore frankly and candidly questions about the client's clarity and comfort regarding their sex and gender identity. The clients are the experts of their own life experiences.

With respect to body language, be mindful of your seated position. For instance, try not to shift in your chair or cross arms or legs as the client discusses the fluidity of sexuality or gender. Understandably, many of these topics might be out of the comfort zone for many providers. The LGBTQ population is accustomed to being judged and, as such, can easily pick up on nonverbal cues. Thus, it is important to be mindful of your body language and nonverbal communication.

The American Psychological Association (APA) has created guidelines for clinicians/facilitators who work with LGBTQ clients (See: American Psychological Association. (2012, January). Guidelines for Psychological Practice Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, American Psychologist, 67, 10-42. http://www.apa.org/pi/lgbt/resources/guidelines.aspx). As per the guidelines, clinicians/facilitators are urged to understand that societal stigmatization, prejudice, and discrimination can be sources of stress and create concerns about personal security for LGTBQ clients. Clinicians/facilitators are also encouraged to avoid attributing a client's non-heterosexual orientation to arrested psychosocial development or psychopathology. Clinicians/facilitators also need to understand that same-sex attractions, feelings, and behaviors are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe. Clinicians/facilitators are encouraged to recognize how their attitudes and knowledge about LGTBQ issues may be relevant to assessment and treatment, and seek consultation or make appropriate referrals when indicated. Clinicians/facilitators should strive to distinguish issues of sexual orientation from those of gender identity when working with LGTBQ clients. Clinicians/facilitators are encouraged to explore with their clients any issues and concerns related to their family of origin and extended family. Clinicians/facilitators

should understand the culturally specific risks of coming out to one's family of origin. For example, racial and ethnic minority families may fear losing the support of their community if they are open about having a LGTBQ child. Clinicians/facilitators are encouraged to increase their knowledge and understanding of non-heterosexuality through continuing education, training, supervision, and consultation.

It is important to consider experiences of victimization and discrimination within this population. Blosnich and Bossarte (2012) found that sexual minorities report more socially-based stressors, such as victimization and discrimination, than heterosexuals. Bisexuals had the highest rates of self-injurious and suicidal behaviors, and intimate partner violence was consistently related to self-injurious behavior.

A very important note here is that clinical signs and symptoms observed in the LGBTQ population should not be assumed different from other populations endorsing the same or similar mental health symptoms. That is, any clinical signs that are known (e.g., difficulties sleeping, hopelessness, loss of interest, racing thoughts, etc.) are the same with LGBTQ as with their non-LGBTQ counterparts. Other clinical signs to consider include isolation or limited socializing, increased alcohol use (McKenry et al., 2006), attachment issues, and sexual coercion. With respect to isolation, as noted in the APA guidelines, LGBTQ individuals gravitate towards individuals with similar feelings and beliefs, and these individuals often become their "families." In terms of attachment style, there is an abundance of literature regarding attachment style, and its impact on the LGBTQ development into adulthood. As such, clinicians/facilitators should spend time exploring and understanding issues related to the family of origin and attachment issues. There is also a spectrum of sexual coercion that should be addressed when working with LGBTQ clients. It is not enough to simply emphasize sexual violence; a wide range of "unwanted" sexual behavior exists within the broader cultural scaffolding that includes more "mundane" forms of sexual coercion (Gavey, 2005). This could make LGBTQ clients less likely to view their sexual misconduct as wrong. Overall, it is important to look beyond the culture of the LGBTQ client. Your client is more than an LGBTQ group member.

TREATMENT INTERFERING FACTORS AND RISK FACTORS

Issues interfering with treatment or risk factors associated with sexual misconduct are not necessarily different when working with the LGBTQ population. It is important to remember that being closed and judgmental will prevent the LGBTQ client from opening up. Putting this in context, Rankin (2005) found that LGBTQ students often hide parts of their identities from their peers, resulting in social and emotional isolation; those who did not hide their identity often faced discrimination, rejection, and harassment. When there is violence in a same-sex relationship, it is sometimes an escalation of ongoing conflict and involves emotional abuse from both partners. Difficulties in conflict resolution and attachment fears appear to explain the occurrence of violence (Stanley et al., 2006). Since violence is often reflected in anger, emotional vocabulary and emotional intelligence (EI) assessments can assist clinicians/facilitators (Stanley et al., 2006). Greater masculinity ("hyper-masculinity") is related to a greater tendency toward aggressive behaviors (McKenry et al., 2006). Further, for males, but not for females, lower self-esteem, lower education level, and lower SES background also contribute to the propensity for violence (McKenry et al., 2006).

LGBTQ-IDENTIFICATION & SEXUAL MISCONDUCT PERPETRATION

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Reed, Pardo, Masumoto, and Amaro (2010) found that GLB students reported feeling less safe on campus, experienced increased stress levels, and had more experiences of threats and victimization compared to their heterosexual peers. These factors resulted in GLB students engaging in more alcohol and drug use than their

peers. Alcohol is a major risk factor for sexual assault and dating violence among sexual minority students (Hequembourg, Parks, Collins, & Hughes, 2015; Ollen, Ameral, Palm Reed, & Hines, 2017). Transgendered individuals were more likely to experience alcohol-related sexual assault than non-transgendered individuals (Coulter et al., 2015). Compared to heterosexual women, lesbian and bisexual women were more likely to report negative drug and alcohol related experiences, such as having unplanned sex after drinking (Esteban McCabe, Boyd, Hughes, & d'Arcy, 2003). Another study, however, found that sexual assault was associated with alcohol abuse in heterosexual women but not in lesbians (Hughes, Johnson, & Wilsnack, 2001).

LGBTQ students also face more barriers to seeking help than their heterosexual peers. Such barriers to help after dating violence and sexual assault among sexual minority students include fear of further marginalization, concerns about injuring the reputation of the community, fear of being "outed," as well as concerns similar to those of heterosexual students, such as feelings of embarrassment and shame (Ollen, Ameral, Palm Reed, & Hines, 2017). Perez and Hussey (2014) noted that colleges and universities may not provide competent treatment for LGBT sexual assault survivors; the treatment provider may ask inappropriate questions or may not have the necessary knowledge, training, or experience regarding the dynamics of sexual violence when the perpetrator and victim are the same gender. Richardson and colleagues (2015) noted that both LGBQ and heterosexual students were reluctant to seek help because they did not believe that the incident was serious enough to report, but LGBQ students were more likely to report that they did not seek help because they believed they would be blamed for the incident.

FRATERNITIES

Fraternities have existed on college campuses in the United States since the founding of the country itself. Originally organized as secret societies promoting fellowship, scholarship, and moral rectitude, many organizations evolved to become more social in nature. The resulting ecosystem has provided fertile ground for sexual misconduct and has been the subject of countless newspaper headlines. Despite a concerted effort in recent years to return organizations to the values and principles on which they were founded, several clear risk factors exist that permit, condone, and in some cases promote sexual misconduct among fraternity members.

Canan, Jozkowski, and Crawford (2016) found that Greek men had greater acceptance of rape myths and endorsed more attitudes about "token" resistance (meaning that when women say no to sex, they really mean yes) than other groups, including non-Greek males. Kingree and Thompson (2013) found that high-risk alcohol use mediates the relationship between membership in a fraternity and sexual aggression. Martin and Hummer (1989) studied the group and organizational practices conditions in fraternities that provide abusive social settings for women. They found that (a) "stereotypical" masculinity (stereotypical attitudes about "masculinity") and heterosexuality, (b) a preoccupation with loyalty, (c) use of alcohol to manipulate women into sex, (d) the prevalence of violence and physical force, and (e) a focus on competition, superiority, and dominance all contribute to the creation of a sociocultural context in which "the use of coercion in sexual relations with women is normative and in which the mechanisms to keep this pattern of behavior in check are

minimal at best and absent at worst," (Martin & Hummer, 1989).

In contrast to their peers, Koss and Gaines (1993) found that fraternity affiliation did not contribute to the prediction of sexual aggression. Similarly, Schwartz and Nogrady (1996) reported that men in fraternities were not more likely to believe in rape myths and concluded that fraternity membership itself is not a useful explanation of why men engage in sexual aggression against women. They found that there is male peer support in fraternities for the victimization of women, but that it is linked to extensive alcohol use. These findings clearly make sense in that any proclivity to rape must be a confluence of multiple factors, and simply belonging to a fraternity, taken in isolation, would not be a risk factor. A study by Nurius, Norris, Dimeff, and Graham (1996) the majority of fraternity men would stop trying to have sex with women who were resisting. Nurius et al. (1996) also reported, however, that these men would be least likely to stop trying to force sex when the woman's resistance was indirect, as compared to more direct forms of resistance. Indirect resistance was the most frequent form of resistance endorsed by previously victimized women in their sample. Notably, these men also assessed women's risk of sexual assault to be higher than the women's own perception of their risk. This latter finding underscores the realistic "real" risk posed those men who are in the best position to estimate the risk.

Taken together, these findings demonstrate that any proclivity to rape must be understood as a confluence of multiple risk factors, and simply belonging to a fraternity is NOT a risk factor in and of itself

Clinical Considerations

When treating a fraternity member who has engaged in sexual misconduct, providers must not indict the fraternity or its culture. It was not the fraternity that committed the sexual misconduct; it was the client. The fraternity becomes important only in-so-far as it stands as an "identity" for that client that reflected intentions for joining that embraced not just partying, not just drinking, but an easy avenue to sex and like-minded peers. It is in that way that fraternity membership becomes a potential issue to explore for that particular student / client. The same forces within the fraternity that may encourage sexual misconduct among a few members may thwart sexual misconduct among other members (e.g., those that hold to creed of honor and integrity). Providers may well wish to remind the client about the historic, founding principles of fraternities, which never included hurting others. At bottom most, however, the focus is on the client, not on the fraternity per se. If the client took advantage of an intoxicated young woman, he alone is responsible (along with anyone else that participated and/or promoted the misconduct).

Providers should be aware that all nationally recognized fraternities have organizational websites that clearly explain the founding principles of the fraternity, as well as providing educational resources for members. Those websites also contain contact information for local, regional, or national officers who can serve as resources for the student or provider. Although the provider is unlikely to communicate directly with a third-party representative of the fraternity (absent a unique and specific request from the client), the provider should be aware that local, regional, and national leaders of the organization are likely to be aware of the incident at issue and will be keen to repair any reputational damage caused to the fraternity as a result of the incident.

Instances Involving Male Victimization

Rape is generally viewed as an act against women. As such, the rape of males is frequently not discussed in educational and prevention programs (Scarce, 1997). However, in a study of 302 male college students, Turchik (2012) found that 51.2% of male students endorsed an experience of sexual violence since the age of 16 and that such incidents were related to higher levels of alcohol use, problem drinking behaviors, tobacco use, sexual risk behaviors, and sexual functioning difficulty.

When working with clients who have victimized another male, providers should be acquainted with the work by Foubert and Perry (2007), who found that empathy-based prevention programs can change athlete's and fraternity member's attitudes and behavior related to male victimization. They reported an increase in understanding of how rape might "feel" (impact victims), and attributed this feeling to watching a video depicting a male-on-male rape scenario (Foubert & Perry, 2007). Similarly, Foubert (2000) and Foubert and Newsberry (2006) found that a rape prevention program led to increased empathy among fraternity members for survivors of sexual assault in general. The program further found a decrease in rape myth acceptance, and the likelihood of committing sexual assault (Foubert, 2000; Foubert & Newberry, 2006).

ATHLETES

Athletes at all levels, high school, collegiate and professional, appear to present disproportionately with a confluence of risk factors that place some of them at increased risk for sexual assault. These primary risk factors are attitudes consistent with negative masculinity, including sexual entitlement and sexual "conquest," and rape myths, and, like a fraternity, supportive peers. In a literature review of the relationship between collegiate athletes and sexual assault, McCray (2015) concluded that student-athletes are inordinately represented among perpetrators of violence against women, and they disproportionately hold attitudes supporting sexual aggression and rape myths. In a study of 925 college women conducted by Fritner and Robinson (1993), victims of sexual assault identified close to one-quarter (22.6%) of the perpetrators of sexual assault as student athletes, as well as 13.6% of perpetrators of attempted sexual assault, and 13.6% of perpetrators of sexual abuse. Similarly, Crosset, Ptacek, McDonald, and Benedict (1996) found that 35% of perpetrators of sexual assault and partner battering across 10 participating educational institutions were identified as student athletes. Koss and Gaines (1993) found that regular use of alcohol and nicotine, hostility toward women and athletic involvement were predictors of severity of sexual aggression. For a relatively recent review of the current literature related to violence perpetrated by male student-athletes see McCray (2015).

These results are not surprising. Athletes, certainly professional athletes, are widely-acclaimed by the mass media as icons of masculinity, veritable symbols of what it means to be "a man." The male hegemonic ideals and values held in sport are integral to the branding of schools and universities and thus highly competitive sport becomes an influential site for the production and reproduction of sexualized masculinity (Prewitt, 2010). Even in high school, these athletes, especially the football players, become gridiron heroes, bringing pride to the school. At the collegiate level, these athletes can account for an immense revenue stream. At the pro-level,

these athletes can become celebrities with great wealth and an entourage of adoring women and admiring men. In sum, athletes may exemplify all that is "masculine," the personification or the embodiment of what real men aspire to – the very best of the best are these "super jocks." Adoration can bring both substantial narcissism and a sense of impunity. Sexual entitlement comes with the territory over the years of socialization for an esteemed and talented athlete. Sex is viewed as a privilege that comes with one's status, a license to have sex with anyone the athlete wants. When sex becomes the athlete's prerogative, mutuality may cease to exist. It is no longer a union, as the term hookup implies; it is an alpha male getting what is rightfully his. In addition, the burden of interpersonal decency related to sex falls on the sexual partner (Prewitt, 2010). In cases that we refer to as negative masculinity, dominance in relationships with women seems to be a key feature of asserting and establishing one's manhood.

Clinical Considerations

When working with athletes there are several considerations that one might keep in mind: 1) loyalty to the team and coaches above all else; there is an insularity and "group think" element dictating that what is best for the team must be preserved and protected at all cost – even in the event of a possible crime; 2) degree of "hyper-competitiveness" (not just on the gridiron with foes but with any rival for the same privileged access to a coveted woman); the existence of a hierarchy based on the individual's standing within the team that is not just confined to the sport; this is the acknowledged "alpha" male on the team; and 4) an elevated status of team membership at the college and in the community at large. This is the backdrop. One of the more challenging risk factors common to highly talented, very successful athletes is the trait of grandiosity or narcissism, reaching a virtual exalted position of athletic nobility among the top tier. What is often called for is a laser focus on the beliefs and attitudes about "self" that have been reified for years by parents, coaches, team mates and adoring fans, and that precludes the humanity of "others." Teaching humility is a steep uphill climb, but it begins by pointing out that everything the student "takes for granted" that should be coming his way should also be granted to others, including the right to say "no."

Team Culture

Culturally, the team unit is important; there is loyalty to the team and to the coach. Often times, the coach is the first line of intervention when an issue about a student athlete is raised, and frequently athletes talk with the coach first before anyone else, including other college or university staff members. It therefore may be helpful (assuming permission is granted) to enlist the support of the coach on some level, as a source of collateral input and potential support. We recommend this advisedly, however. Often, coaches are, themselves, part of a co-created microcosm. The coaches, twenty years earlier, were the star athletes; they were "taught," or learned that the most coveted women, likely the cheerleaders, wanted them and fought each other for access to them. In-other-words, the coaches often hold the arrogance, cockiness, pretension, cultural hubris as their star athletes. So, unfortunately, coaches are likely to say everything was blown out of proportion and "she" (the victim) was just a "jersey chaser." It simply is a reminder of the echo-chamber that the athletes have lived in since their remarkable talents were noted as a sophomore in high school.
This is particularly important when the student reintegrates fully to campus activities after completing their

sanction. Coaches might be enlisted in helping to address a student's reluctance to engage in treatment. Coaches can help reinforce the importance of taking treatment seriously and attending sessions. Or likely as not, the coach will enforce the requirement to attend so he gets his athlete back on the field, but tell his athlete, "look, we know it's all nonsense, but go anyway and make them happy."
This is not all coaches. Some research suggests that coaches can be instrumental in combating sexual aggression by establishing clear expectations of appropriate behavior, as well as consequences for deviating from expected behavior. For example, significant associations between the coach's expectations and discipline for off-field transgressions and bystander interventions have been found for Division II and III athletes, suggesting the importance of the coach in communicating and establishing acceptable standards of behavior (Kroshus, Paskus & Bell, 2015).

Please review https://appliedsportpsych.org/about/ethics/ethics-code/

In addition to the emphasis on teamwork, there are many other positive elements of athletic culture, such as discipline, training to enhance or develop skills, drive and ambition, competitiveness, and perseverance, all of which, when present in moderation, are highly effective skills outside of sports. The provider can assess these areas and use them as strengths to build on that can be translated to other areas of the student's life. The importance of a student's hierarchy on the team should not be overlooked and having the respect of one's teammates is important. Just like any peer group, some teammates will have positive and healthy attitudes about sex and dating, while other teammates will embrace negative and high-risk attitudes. Addressing this in treatment and helping the student manage negative attitudes and behaviors exhibited by some teammates when returning to campus is crucial, particularly if the student's status is lower on the hierarchy or they are not in a team leadership position. If they are in a team leadership position or have a higher standing or status, the provider could work with them about what it means to be a role model for other teammates and how they can effect positive change on their team. Achieving this can be difficult, however. The higher the status of the student, the more the student may feel he has to lose by being "exposed" or unjustly targeted or made a scapegoat, or simply embarrassed. The higher the status, the greater the fall. Exploring the stressors of collegiate sports is also important – the extremely high expectations of winning – the accolades when you do and the criticisms and excuses when you don't. In general, the meaning of sports and athletic competition in their life and the pros and cons of how it might impact their relationships and behaviors can be explored. Overall, much additional work will likely be needed if the student was involved in a highly publicized case. When a case "goes viral," it is not just his teammates that he has to worry about but the entire college community – and conceivably beyond.

REACTIONS TO THERAPY

Students referred for therapy as a result of sexual misconduct may have a wide range of emotional reactions. Some are likely to be angry, defiant, and resistant to the idea that they "need" therapy. Some are likely to place full or partial responsibility on the victim, while others may be embarrassed, feel ashamed, and be hesitant to speak about the "incident(s)." Their emotional responses are further likely to be enhanced by

the feedback they get from their peers, their family, and others they choose to confide in. When feedback is not only highly supportive but condemnatory, disparaging and fault-finding of the victim, it will cement the student's resistance. In addition, however, students may bring other strong emotions stemming from their life experiences, including their own abuse (McCray, 2015). Adverse life experiences may include underlying anger, depression, or anxiety. The vast majority of college students are still, developmentally, adolescents, and a hallmark of adolescence is emotional instability and strong emotional reactions. A central task of therapy may be to try to place in context the incident(s) that brought the student into therapy, and to help the student understand and come to terms with this "outcome" as part of a larger panoply of issues that he/she is dealing with (e.g., social/dating skills, social self-confidence, identity as a man or a woman, global self-esteem, or generalized anger and resentment).

Final Clinical Considerations

Direct, open, and honest discussion between client and provider is imperative. The client should be assured that there is nothing wrong about having sex and, moreover, that young men and women of all races, ethnicities, religions, and sexual orientations enjoy having sex. Sex can be a lot of fun, but only when both people want it and it is fully consensual. Students must learn to feel comfortable talking about sex and to actively express their needs, desires, and limits. Men must learn to respect women's wishes and needs and to communicate about mutual preferences and needs. Likewise, women need to feel comfortable doing the same. Communication goes two ways. Respecting other's needs is the mature thing to do. Ignoring or disregarding someone's needs or wishes is not only harmful to the woman but disrespectful to yourself. Despite the high-5s from your friends the next day, it's hard to feel any sense of esteem when you know privately that you had to get her drunk in order to have sex. Ultimately, we are teaching little more than mutual respect.

Lastly, providers should be mindful that some (very few) clients that present as highly narcissistic and/or with other psychopathic traits (e.g., manipulative, deceptive, superficially charming, grandiose / bragging to impress, absence of any sense of regret or remorse, failure to accept any responsibility), along with misconduct that has other antisocial elements (e.g., criminogenic attitudes, threats, attempt to demean, degrade or denigrate the women by name-calling - slut, bitch, whore, etc.) are likely to play along with you, entertain you, and convince you of their inherent goodness, boast of their accomplishments (why would I need to rape her? I've got 7 I'm already bedding). Expecting them to express any genuine feelings will be unrealistic. Expecting them to discuss their social life, their prior relationships with women, and their past sexual experiences may be futile. The most important suggestion is to keep your eyes wide open and not be fooled by the guile, the jive, the artifice, and the run-around that characterizes the very few clients that present with psychopathic features.

Useful Guidelines:

American Psychological Association. (2012, January). Guidelines for Psychological Practice Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, American Psychologist, 67, 10-42. http://www.apa.org/pi/lgbt/resources/guidelines.aspx

Guidelines for assessment of and intervention with persons with disabilities. (2012). American Psychologist, 67, 43-62. doi:10.1037/a0025892 http://www.apa.org/pi/disability/resources/assessment-disabilities.aspx

American Psychological Association. (2015, December). Guidelines for Psychological Practice With Transgender and Gender Nonconforming People. American Psychologist, 70, 832-864. https://www.apa.org/practice/guidelines/transgender.pdf

American Psychological Association. 2017. Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality. http://www.apa.org/about/policy/multicultural-guidelines.pdf

Guidelines for Psychological Practice With Girls and Women. (2007). American Psychologist, 62, 949-979. doi:10.1037/0003-066X.62.9.949

Guidelines for Prevention in Psychology. (2014). American Psychologist, 69, 285-296. doi:10.1037/a0034569. http://www.apa.org/pi/lgbt/resources/guidelines.aspx

http://www.apadivisions.org/division-47/
https://appliedsportpsych.org/about/ethics/ethics-code/
https://www.acsm.org/acsm-membership/membership/join/acsm-member-code-of-ethics

APPENDIX C

Informed Consent Packet

POSSIBLE COMPONENTS OF INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

1. **Nature, purpose and course of treatment including information about treatment effectiveness.**
   - General information about psychotherapy
   - Specific information about this program – CBT, RNR, session format, OSA

2. **Confidentiality and limits**
   - HIPAA, FERPA policy information
   - Standard limits of confidentiality including what information will be reported back to the university at the completion of treatment.

3. **Fees and cancelation policies**
   - Please include your cancelation policy (24/48 hours, etc.)
   - Fees per session and cost for no shows

4. **Professional Records**

5. **Contacting the therapist and other rights**

PRELIMINARY PREPARATION FOR THE INFORMED CONSENT

Note:

Throughout this document, the terms student and client may appear interchangeably. Although the referral sources (the Title IX and Student Conduct officers) will, of course, use "student," we recommend to clinicians that the students be referred to by their therapists as "clients" to emphasize the protected nature of the relationship.

Prior to treatment and preparing the informed consent form, communicate with the referring school. Initial communication with those who made the referral is essential for establishing the reasons for the referral and the college/university's expectations going forward. We recommend maintaining confidentiality and if anything is to be reported to the school, it is simply a verbal affirmation about compliance and completion. A signed release to provide a verbal confirmation about compliance and completion must be obtained.

Obtain a release of information signed by the student from the referring institution, any relevant records from the institution and a copy of the CFC (Contributing Factors Checklist). If the client is suspended and seeking treatment without the initial point of contact originating from the institution or representative of that institution, obtain a release from the college/university that is signed by the student client granting permission for the college/university and clinician to speak.

The therapist should obtain all relevant information about the student prior to the first session, including all available information about the incident of sexual misconduct, testimony from the Complainant, the respondent, and any witnesses and any prior relevant conduct-related information from the institution about the student. An initial determination may have to be made regarding the focal treatment needs presented by the student (e.g., a primary need for substance abuse treatment, or symptoms suggestive of major mental illness, or acute anxiety associated with possible PTSD).

The following template is presented as a guideline for what information could be shared with the institution upon the completion of treatment.

It is only recommended that the clinician answer simple y-n about treatment attendance, compliance and

successful completion.

- Number of sessions completed (to date or in total if submitted at completion)
- Attended/ing sessions as scheduled, problems with attendance, no shows
- Treatment compliance (e.g., effort, motivation, engagement).

A student may revoke their authorized release for the therapist to provide confirmation about compliance and completion. The student should be informed of this right and that a revocation of release does not apply retroactively (i.e., if a therapist has provided information about compliance prior to the revocation). In others the revocation would apply only going forward.

The therapist should inform the client that the client should discuss this with the school, as once the release is revoked, the therapist cannot provide any information about compliance or completion and therefore the student may not be able to return to their regular standing at the school, until they receive confirmation from a therapist. The therapist should direct the client to discuss this with their college or university.

SAMPLE INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES AS PART OF THE STARRSA PILOT PROGRAM

[INSERT LETTERHEAD]

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

This document contains important information about [my/our] professional services and business policies. [INDICATE WHETHER THEY WILL RECEIVE SPECIFIC ADDITIONAL INFORMATION ABOUT HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), A FEDERAL LAW THAT PROVIDES PRIVACY PROTECTIONS AND PATIENT RIGHTS ABOUT THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION (PHI) FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.] Although these documents are long and complex, it is important that you try to understand them. When you sign this document, it also represents an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by you and by me, your therapist. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy may require discussing unpleasant aspects of your life. However, psychotherapy has been shown to have clear benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, better problem solving and occasionally resolutions to specific life problems. But, there are, of course, no guarantees. The biggest factor of all is you – how seriously you take our sessions, and how

much work and effort you put in the process. I am your guide, but you are the one who must blaze the trail. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on the things we discuss outside of sessions.

STARRSA (SCIENCE-BASED TREATMENT, ACCOUNTABILITY AND RISK REDUCTION FOR SEXUAL ASSAULT) INTERVENTION

This program was developed specifically to help those college students that were found responsible for sexual misconduct. It was designed by a team of psychologists with expertise in clinical psychology, sexual misconduct, risk assessment, and public health. As part of this program, I will assess factors related to sexual misconduct that are specific to you, as well as assess your treatment needs that are related directly to those factors. Our work together will be tailored to target those factors. Factors can be thoughts, attitudes, feelings, and situations that are related to sexual misconduct for you. Needs refer to treatment interventions that are intended to target those factors identified as important for you.

The treatment approach for this program is called Cognitive Behavioral Therapy. It looks at how thoughts, feelings and behaviors are related. This approach helps you understand the thoughts and feelings that are related to risky and harmful behaviors, specifically to sexual misconduct. It will also help you learn how to develop healthier patterns of thinking and behaving. It will help you identify risky thoughts, behaviors and situations and develop better ways for managing those situations. The overall goal is to help you develop healthier, more gratifying sexual (and non-sexual) relationships with women (men), not just here in college but over your lifetime.

The first 1-2 sessions will involve an evaluation of your risks and needs. To be clear again, “risks” are things that appear to have been related, to one degree or another, with your sexual misconduct. “Needs” are things that must be addressed to mitigate (lessen) the risks. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and the areas of focus. At that point, we will discuss your treatment goals and create an initial treatment plan. If you have questions about my procedures, we should discuss them whenever they arise. If you do not wish to continue, then please tell me now. I will have to notify your college.

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

[ADJUST THE FOLLOWING AS NECESSARY] My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document, and we have discussed those issues. Please remember that you can re-visit these issues at any time during our work together.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent to anyone, except the referring college/university. My formal Mental Health Record describes [ADJUST AS NEEDED] the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign this informed consent document that includes these limits of confidentiality and indicates that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. There are two parts to these limits, standard limits of confidentiality and those that are specific to the treatment required or recommended by your college/university:

Specific limits of confidentiality:

- As part of the treatment sanction required or recommended by your institution, I will share the following information with your university/college
- Number of treatments & attendance
- [INSERT as per agreement with university/college. Be sure the items listed here are reflected in the Treatment Completion Summary document that you intend to utilize post-treatment and be mindful of over disclosures of personal information.]
- If the university/college requests additional information beyond the above referenced items, I will inform you first about the information that has been required then you and I will determine whether that information should be disclosed. No additional information will be disclosed without your consent.

Standard limits of confidentiality:

In the following circumstances, I may use or disclose records or other information about you without your consent or authorization, either by policy, or because legally required [INSERT APPLICABLE STATE SPECIFIC AND INSTITUTION SPECIFIC POLICIES]:

- **Emergency:** If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the [X STATE] Department of Social Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by [X STATE] to immediately make a report and provide relevant information to [ ].
- [ONLY IF APPLICABLE] **Health Oversight:** [X STATE] law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. [INSERT STATE] licensing boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- **Serious Threat to Health or Safety:** Under [INSERT STATE] law, if you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat, I am legally required to take steps to protect such individuals. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission. [This sentence is now required under the HIPAA "Final Rule."]

APPOINTMENTS

Appointments will ordinarily be [INSERT TIME] 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24-hour's notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect [INSERT APPROPRIATE AMOUNT (e.g., co-payment] from you personally [unless we both agree that you were unable to attend due to circumstances beyond your control]. This treatment is being supported by a federal grant, but if you miss a session without 24-hour's notice, you will be responsible for the fee described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The fees for this program are covered by the federal grant. Should you miss a scheduled appointment without prior notification as outlined above, you will be charged [INSERT FEE AMOUNT].

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnoses (if applicable), topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONTACTING ME

[INSERT POLICIES] I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You are free to end therapy at any time, but the university/college who referred you will be notified, which may impact your enrollment status. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and agree to their terms.

_____

Signature of Patient

_____

Clinician

_____

Date

APPENDIX D

The Guide to Risk, Needs, and Interventions in the Treatment Manual

- **(Provides a link between the RNI items and modules).**

A GUIDE TO RISKS, NEEDS, AND INTERVENTIONS IN THE TREATMENT MANUAL

Risk factors and treatment needs are identified and woven in throughout the treatment program. Some clear links between assessed treatment needs and treatment components are highlighted in the table below.

Accepting Responsibility for all Sexual Behavior	**Module 1: Assessment & Treatment Planning** **Module 2: Sexual Behavior & Sexual Misconduct** **Module 3: Focus on Socialization & Sexualization in Society** • Session 2: Sexual Knowledge, Risky Sex, and Sexual Misconduct **Module 4: Understanding & Resolving Risks for Sexual Abuse** • Session 1: Risky Attitudes • Session 2: Risky Feelings • Session 4: Risky Situations • Session 5: Substance Use & Sexual Abuse **Module 7: Behavior is a Choice: Choosing Wisely** • Session 1: The ABCs of Human Behavior • Session 2: My Values and Goals: Who I Am and Who I Want to Be • Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations **Module 8: Healthy Relationships** • Session 1: Friendships and Partners • Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others • Session 3: Communicating Effectively: Interpersonal and Dating Skills • Session 4: Developing Positive Relationships • Session 5: How Does Sex Fit in My Life? **Module 10: Wrapping Up & Going Forward** • Session 1: What Have I Learned? Assessment & Feedback • Session 2: Plans for Healthy Living: Going forward

Internal Motivation for Change

Module 1: Assessment & Treatment Planning

Module 7: Behavior is a Choice: Choosing Wisely

Module 3: Focus on Socialization & Sexualization in Society

- Session 2: My Values and Goals: Who I Am and Who I Want to Be

Module 10: Wrapping Up & Going Forward

- Session 1: What Have I Learned? Assessment & Feedback
- Session 2: Plans for Healthy Living: Going forward

Sexual Self-Regulation

Module 2: Sexual Behavior & Sexual Misconduct

Module 3: Focus on Socialization & Sexualization in Society

- Session 1: Gender Socialization & Sex
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Peer Influences

Module 5: Negative Masculinity

- Session 1: What Is Negative Masculinity?
- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 8: Healthy Relationships

- Session 1: Friendships and Partners
- Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others
- Session 3: Communicating Effectively: Interpersonal and Dating Skills
- Session 4: Developing Positive Relationships
- Session 5: How Does Sex Fit in My Life?

Regret / Remorse for Sexual Misconduct

Module 6: Consequences of Sexual Abuse

- Session 1: Impact of Sexual Misconduct
- Session 2: Effects of Sexual Misconduct on Victims/Survivors

Module 9: Accountability: Making Amends and Making a Difference

- Session 1: Accountability and Responsibility
- Session 2: Making Amends and Making a Difference

Attitudes/ Beliefs Regarding Sexual Misconduct

Module 3: Focus on Socialization & Sexualization in Society

- Session 1: Gender Socialization & Sex
- Session 3: Peer Influences

Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 1: Risky Attitudes
- Session 2: Risky Feelings
- Session 4: Risky Situations
- Session 5: Substance Use & Sexual Abuse

Module 5: Negative Masculinity

- Session 1: What Is Negative Masculinity?
- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 8: Healthy Relationships

- Session 1: Friendships and Partners
- Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others
- Session 5: How Does Sex Fit in My Life?

Victim Impact/ Empathy

Module 6: Consequences of Sexual Abuse

- Session 1: Impact of Sexual Misconduct
- Session 2: Effects of Sexual Misconduct on Victims/Survivors

Module 9: Accountability: Making Amends and Making a Difference

- Session 1: Accountability and Responsibility
- Session 2: Making Amends and Making a Difference

Emotional Self-Regulation

Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 1: Risky Attitudes
- Session 2: Risky Feelings
- Session 3: Risky Behaviors
- Session 4: Risky Situations
- Session 5: Substance Use & Sexual Abuse

Module 7: Behavior is a Choice: Choosing Wisely

- Session 1: The ABCs of Human Behavior
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations

Behavioral Self-Regulation

Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 1: Risky Attitudes
- Session 2: Risky Feelings
- Session 3: Risky Behaviors
- Session 4: Risky Situations
- Session 5: Substance Use & Sexual Abuse

Module 5: Negative Masculinity

- Session 1: What Is Negative Masculinity?
- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 7: Behavior is a Choice: Choosing Wisely

- Session 1: The ABCs of Human Behavior
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations

Alcohol Use and Abuse

Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 5: Substance Use & Sexual Abuse

Module 7: Behavior is a Choice: Choosing Wisely

- Session 1: The ABCs of Human Behavior
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations

Social Orientation and Engagement

Module 3: Focus on Socialization & Sexualization in Society

- Session 1: Gender Socialization & Sex
- Session 2: Sexual Knowledge, Risky Sex and Sexual Misconduct
- Session 3: Peer Influences

Module 5: Negative Masculinity

- Session 1: What Is Negative Masculinity?
- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 8: Healthy Relationships

- Session 1: Friendships and Partners
- Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others
- Session 3: Communicating Effectively: Interpersonal and Dating Skills
- Session 4: Developing Positive Relationships
- Session 5: How Does Sex Fit in My Life?

Module 10: Wrapping Up & Going Forward

- Session 2: Plans for Healthy Living: Going forward

Social Competence

Module 5: Negative Masculinity

- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 7: Behavior is a Choice: Choosing Wisely

- Session 1: The ABCs of Human Behavior
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations

Module 8: Healthy Relationships

- Session 1: Friendships and Partners
- Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others
- Session 3: Communicating Effectively: Interpersonal and Dating Skills
- Session 4: Developing Positive Relationships
- Session 5: How Does Sex Fit in My Life?

Module 9: Accountability: Making Amends and Making a Difference

- Session 1: Accountability and Responsibility
- Session 2: Making Amends and Making a Difference

Peer Relationships

Module 3: Focus on Socialization & Sexualization in Society

- Session 1: Gender Socialization & Sex
- Session 3: Peer Influences

Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 1: Risky Attitudes
- Session 2: Risky Feelings
- Session 4: Risky Situations
- Session 5: Substance Use & Sexual Abuse

Module 5: Negative Masculinity

- Session 1: What Is Negative Masculinity?
- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 7: Behavior is a Choice: Choosing Wisely

- Session 1: The ABCs of Human Behavior
- Session 2: My Values and Goals: Who I Am and Who I Want to Be
- Session 3: Recognizing and Managing Risky Thoughts, Feelings, Behaviors and Situations

Module 8: Healthy Relationships

- Session 1: Friendships and Partners
- Session 2: Perspective Taking and Empathy: Understanding and Caring about the Needs, Wants and Feelings of Others
- Session 3: Communicating Effectively: Interpersonal and Dating Skills
- Session 4: Developing Positive Relationships

Mentors or Other Prosocial Supports

Module 5: Negative Masculinity

- Session 2: Moving from the Abstract to the Personal (Healthy Masculinity)

Module 8: Healthy Relationships

- Session 4: Developing Positive Relationships

APPENDIX E

Risk Needs Inventory

- **Risk Needs Inventory Face Sheet**
- **Risk Needs Inventory Manual**
- **Brief Assessment and Interview Guide for the RNI**

SEXUAL MISCONDUCT RISK & NEEDS INVENTORY FACE SHEET

Name: _____

Age: _____

Note: Intake _____ Interim _____ Final _____ Dates covered: _____

Treatment status: Active _____ Dropped out _____ Completed _____

Number of sessions this period: Offered _____ Completed _____ Refused _____

Treatment Objectives/Needs	No/Minimal Need	Moderate Need	Significant Need
1. Accepting Responsibility for All Sexual Behavior	0	1	2
2. Internal Motivation for Change	0	1	2
3. Sexual Self-Regulation	0	1	2
4. Attitudes/Beliefs Regarding Sexual Misconduct	0	1	2
5. Regret /Remorse for Sexual Misconduct	0	1	2
6. Victim Impact / Empathy	0	1	2
7. Behavioral Self-Regulation	0	1	2
8. Emotional Self-Regulation	0	1	2
9. Alcohol Use and Abuse	0	1	2
10. Social Orientation and Engagement	0	1	2

11. Social Competence	0	1	2
12. Peer Relationships	0	1	2
13. Intimate Relationships and Sexual Behavior	0	1	2
14. Mentors or Other Prosocial Supports	0	1	2
15. Other*	0	1	2

***Other Goals (optional):**

Therapist Signature: _____ **Dates completed:** _____

RISK NEEDS INVENTORY – MANUAL

INTRODUCTION:

This Risk and Needs Inventory (RNI) is intended to facilitate the clinical assessment of dynamic (changeable) risk factors that have been identified in the empirical literature as associated with the risk of sexual misconduct among college students as well as sexual re-offense in juvenile and adult offenders. Identified risk factors on the RNI may point to treatment needs to be addressed. Not every risk factor will be relevant to a particular individual and some factors - indicating the relative absence of risk - may be protective (e.g., the absence of abuse supportive attitudes and beliefs).

The RNI provides a convenient way to target and summarize risk-relevant treatment areas, progress over time, or lack thereof, and communicate this information to the client and, when appropriate, referral sources. Newly identified treatment needs and objectives may be added at any time. Similarly, previously identified risk factors may resolve due to a positive treatment response. Re-assessments may point to progress in specific treatment needs, as well as help prioritize current treatment needs.

The RNI is not a risk assessment instrument designed to predict who may engage in future sexual misconduct. It has not been developed or validated for that purpose. It is intended to be used as a guide to assist the clinician in identifying the most critical, misconduct-relevant risk factors to target in treatment. The overriding goal is mitigating risk associated with misconduct and reduce the likelihood of re-occurrence of such misconduct. Although research validating the RNI's utility as a treatment planning guide and measure of treatment progress is encouraged, it was not part of the present project.

As indicated on the Rating Form, items are rated with a 0 to 2 format.
A zero (0) rating indicates that the risk factor does not currently appear to require treatment intervention or presents as a minimal need (No/Minimal Need = 0); in some instances, a zero may reflect a strength or protective factor (e.g., Prosocial Attitudes/Beliefs Regarding Sexual Misconduct).

A **one** (1) indicates that the risk factor has a moderate treatment need (Moderate Need = 1).

A **two** (2) indicates that the risk factor has a "significant" treatment need requiring "significant" intervention (Significant Need = 2).

When the RNI is re-administered during the course of treatment, lowered ratings on previously rated factors presumably reflects treatment progress, whereas higher ratings may reflect a need for more intensive intervention. Behavioral anchors and descriptors are provided in the accompanying RNI Manual to assist with item ratings.

RNI ratings should be based on multiple sources of information whenever possible, such as school and other available records, as well as self and credible collateral reports. If available information is limited, incomplete, or unclear, items should be scored in the direction of lower risk (favoring the absence rather than the presence of the item), and it should be noted that the resulting ratings may underestimate need, and require further assessment. In addition, if available information is insufficient for any rating, leave the item blank and target that item for further assessment in subsequent sessions.

Additional relevant assessment measures (such as social skills rating scales) may be helpful for assessing treatment needs and measuring behavior change.

CAVEAT

When assessing risk and protective factors with students who have engaged in sexual misconduct, the stakes are often very high, both for the complainant as well as the respondent. We have an enormous burden of responsibility to both. On the one hand, we use our assessments to guide interventions designed to reduce the risk of further sexual misconduct and encourage respectful, consensual, and safe sexual behavior, thereby helping to protect campuses and the larger society from unsafe and abusive sexual behavior. On the other hand, if misused or misapplied, our assessments and interventions may result in significant, unintended, deleterious consequences for students, including those with relatively few risk factors and strong protective ones.

Consequently, it is imperative that clinicians who assess risk and related treatment needs among college students who have engaged in sexual misconduct be knowledgeable of the challenges involved in assessing this population. Although, in most instances college students are legally adults, most of them are developmentally and emotionally adolescents. Their cognitive, neurocognitive, social, emotional development are still evolving. Further, their life circumstances are exceptionally fluid as they are in transition from the tighter supervision typically provided by their parents and caregivers during high school to the newfound freedoms and temptations of college life. This period is very much a time of change. Developing an accurate treatment plan can be not only challenging but ephemeral, with identified risk factors changing, requiring modifications in interventions and apparent progress uncertain. Treatment needs may change, sometimes dramatically, in a relatively brief period of time. Therefore, we strongly recommend that risks and needs be assessed not just at intake but reassessed periodically thereafter, with a final RNI assessment completed at the end of treatment. Re-assessments should be done even more often if risk-relevant life changes occur.

Prior to using the RNI, users should, ideally, have training and experience in assessing the treatment needs of college-age students in general, as well as those who engage in sexual misconduct. Users should read this manual and be familiar with its contents. Although we recognize that it is likely to be quite unrealistic, ideally, before using the RNI, users should complete some practice or training cases and compare their ratings with others who have rated the same individual to identify and resolve any rating difficulties. It is also recommended that RNI users periodically consult with the STARRSA team and/or colleagues about item ratings, when possible, stay current with the evolving literature relevant for on assessing and treating college students who engage in sexual misconduct.

RISK & NEEDS INVENTORY MANUAL

ITEM 1: ACCEPTING RESPONSIBILITY FOR ALL SEXUAL BEHAVIOR

Description:

Accepting responsibility for all sexual behavior means assuming responsibility for ensuring sexual behavior is consenting and safe. It also includes not excusing, denying, or disowning the misconduct, minimizing its seriousness, or significantly redirecting or assigning some or all of the responsibility for the misconduct to others or to circumstances (e.g., the individual does not place blame on the victim, on friends/buddies or acquaintances, on society, on the campus police, or on college or university rules).

Ratings:

0 - No or Minimal Need
Appears to genuinely understand the need to take responsibility and assume personal responsibility for consenting and safe sexual behavior. Currently assumes responsibility for prior sexual misconduct without evidence of significantly redirecting responsibility or excusing the misbehavior.

1 - Moderate Need.
Individual expresses some awareness of personal responsibility for managing sexual urges and behavior respectfully and safely. The individual generally accepts some responsibility for sexual misconduct, although occasional excusing or redirecting responsibility may be present. If the individual denies responsibility for the referral sexual misconduct, such denials appear related to embarrassment, humiliation, and fears of social rejection rather than sexual entitlement or misogynistic views, and the individual assumes responsibility for sexual behavior in most instances.

2 - Significant Need
Individual evidences no awareness of the importance of taking full personal responsibility for managing one's sexual behavior appropriately, consensually, and safely. Score 2 when there is significant or frequent redirecting or excusing responsibility, for example the individual may not accept any responsibility for the referral sexual misconduct or there is persistent denial or disavowal that any such misconduct occurred. Sexual entitlement or misogynistic views may be voiced, as well as attributions of victim responsibility (e.g., her attire, she drank of her own free will, she came upstairs with me willingly, etc.).

ITEM 2: INTERNAL MOTIVATION FOR CHANGE

Description:

The intent of this item is to assess the extent to which the individual truly experiences sexual misconduct as "out of character" **and** genuinely desires to make necessary changes to avoid any recurrences.

Ratings:

0 - No or Minimal Need
Appears distressed by having engaged in sexual misconduct and appears to have a genuine desire to make necessary changes to ensure such behavior does not reoccur. Once in treatment, client attends sessions routinely and participates actively. Compliance with treatment activities is consistently good.

1 - Moderate Need.
There is some motivation to make positive change along with a degree of internal conflict and distress about engaging in sexual misconduct. Yet, the motivation is mixed with a clear desire to avoid external "consequences" associated with additional sexual misconduct or noncompliance with school sanctions. Attends sessions possibly with occasional unexcused absences; participation may vary in quality. Homework compliance may generally be sufficient, but the quality may be just passable.

2 - Significant Need
Does not perceive a need to change behavior or engage in treatment. The individual may arrive late and be uninvolved, sarcastic, surly or antagonistic in sessions. There may be many unexcused absences. Compliance with treatment assignments may be limited or poor.

ITEM 3: SEXUAL SELF-REGULATION

Description:

This item concerns how well the individual has managed and controlled sexual arousal and urges appropriately during the past six months, excluding the sexual misconduct that prompted the instant referral. Problems with sexual self-regulation may be evident, for example, by frequent inappropriate sexual comments, gestures, and drawings and sexual harassment that does not remit in spite of corrective feedback, or by nonconsenting sexual touching or more intrusive sexual behaviors, as well as by repeated viewing of misogynistic or sexually crude and disrespectful images/videos. Being preoccupied with sexual thoughts,

fantasies, and/or behavior also may indicate problematic sexual regulation. Sexual preoccupation may be indicated, for example, when pornography use, or other sexual behavior, is so frequent it interferes with or impairs the person's ability to engage in normative activities (e.g., academic or work responsibilities and/or prosocial endeavors and relationships). Preoccupation may include excessive or compulsive online sexual activities, such as repeated and frequent viewing Internet pornography, visiting sexually themed chat rooms, viewing online sexual shows, engaging in sexual activities with another person(s) via the Internet through chat or a webcam via a computer or smart phone. The individual may describe difficulties managing these urges and "giving in" to these "impulses" and, as noted above, these sexual activities interfere with or impair normative behaviors and functioning. Recent, additional, credible reports of sexual misconduct, (other than the sexual misconduct that prompted the current referral), such as founded school reports in addition to the misconduct that prompted the referral, self-reports of problems managing sexual urges, or charged offenses within the last six months reflect significant sexual self-regulation problems.

Ratings:

0 - No or Minimal Need
The individual appears to manage and control sexual arousal and urges appropriately, safely, and consensually and can describe strategies for doing so. With the exception of the referral offense, sexual urges, thoughts, fantasies, and behavior do not seem to interfere with normative activities.

1 - Moderate Need.
Sexual arousal and urges appear to be managed appropriately, safely, and consensually most of the time; however, noncontact, inappropriate sexual behaviors may occur occasionally (e.g., inappropriate sexualized comments and gestures). Preoccupation with sexual thoughts, fantasies, and/or behaviors may sometimes interfere with normative activities, (e.g., prolonged viewing of pornography rather than completing homework or socializing with peers). If there have been significant problems with sexual-regulation in the past, a rating of 1 may be used to reflect recent improvement, for example, as indicated by increased skills for managing sexual arousal and urges, as well as an apparent improvement in managing sexual urges and behavior.

2 - Significant Need
Sexual self-regulation is problematic. The individual continues to have difficulties managing and controlling sexual arousal and urges appropriately, safely, and/or consensually. Problems with sexual self-regulation may include, for example, inappropriate sexual comments, gestures, and drawings, crude sexual comments send via tweet, email or posted (e.g., Facebook), sexual harassment, nonconsenting sexual touching or more intrusive sexual behaviors, as well as viewing misogynistic or sexually crude and disrespectful images or videos. There may be frequent preoccupation with sexual thoughts, fantasies, and behaviors that interfere with normal daily activities. Rate 2 for any additional credible reports of person-involved sexual misconduct (other than the sexual misconduct that prompted the current referral), or additional founded school reports or charged offenses within the last six months. Also, rate 2 at intake for any prior credible reports of sexual misconduct in addition to the referral misconduct, (e.g. additional founded school reports, or a history of charged offenses), that extend beyond the past six months). If this item is rated a 2 at intake because of prior instances of sexual

misconduct or offending, it may be reassessed during treatment and a rating of 1 or even 0 may be used to reflect recent improvement, for example, as indicated by increased skills for managing sexual arousal and urges, as well as an apparent improvement in managing sexual urges and behavior.

ITEM 4: ATTITUDES/BELIEFS REGARDING SEXUAL MISCONDUCT

Description:

This item includes a range of attitudes and beliefs regarding sexual misconduct, from those that support or condone sexual misconduct on one end of the spectrum to those that oppose and are against sexual misconduct on the other end. Attitudes that support and justify sexual misconduct may be indicated by statements such as she was "partying," he/she "wanted it" or "she/he deserved it," she was "looking for it," she was "dressed sexy," most girls want it but "play" coy, or simply the person never said no. Attitudes and beliefs that may support sexual misconduct often include cynicism about women's "motives" in claiming rape and discounting or trivializing the victim's report.

Negative masculinity, male privilege and misogyny, frequently cloaked in negative attitudes and beliefs about women, may include sexual objectification and hostility toward women as well as more entrenched abuse-supportive attitudes and beliefs reflecting sexual entitlement (e.g., that a man has the right to sex, regardless of the other person's wishes), and sometimes may involve sexual misconduct justified by an intolerance of non-heterosexual, alternative sexual orientations, and non-binary gender identifications.

Although attitudes and beliefs that support sexual misconduct may occasionally be associated with inaccurate, misguided, or erroneous information about healthy, respectful, and consensual sexual behavior, more often there are deeply held attitudes and beliefs that support, justify, and condone sexually aggressive behavior. The relative absence of such misogynistic attitudes would be reflected in respectful and egalitarian, emotionally and sometimes sexually intimate interpersonal relationships with women. The same principle applies, however, regardless of gender, orientation, or sexual identity and partner preference.

Ratings:

0 - No or Minimal Need
Appears genuine in expressing prosocial attitudes and beliefs that support respectful, egalitarian interpersonal relationships, and truly believes that sexual behavior should be consenting, safe, and respectful. Attitudes and beliefs are inconsistent with sexual misconduct, and appear internalized at an affective level. Attitudes and beliefs that support or justify sexual misconduct are completely absent.

1 - Moderate Need.
Expresses occasional attitudes and beliefs that support or justify sexual misconduct behaviors (e.g., it's okay, when you're drunk), yet, increasingly identifies such attitudes and beliefs as incorrect and, more and more, uses strategies to correct them (e.g., self-statements that challenge previously held erroneous beliefs; e.g., acknowledging that "drunk sex" does not make engaging in sexual misconduct okay). Score 1 if attitudes and beliefs that support sexual misconduct appear associated with insufficient knowledge about healthy, respectful and consensual sexual behavior rather than deeply held beliefs, or if expressed prosocial attitudes and beliefs appear to be simply statements that are not genuinely held or fully integrated into the person's approach to life.

2 - Significant Need
Individual evidences frequent attitudes and beliefs that support or justify misconduct (e.g., sexual entitlement, misogynistic attitudes justifying sexual misconduct, intolerance of non-heterosexual, alternative sexual orientations that also rationalize sexual misconduct, trivializes the impact of rape, and endorsing or supporting a culture of rape by minimizing or discounting widespread negatives attitudes in society about women and sexual minorities). These attitudes and beliefs supportive of sexual misconduct may be entrenched and reflect the person's world view.

ITEM 5: REMORSE FOR SEXUAL MISCONDUCT

Description:

This item concerns the extent to which the individual truly is remorseful about the sexual misconduct. Thoughts and sentiments that reflect remorse for the sexual misconduct are genuinely expressed, as may be emotions and feelings of guilt or self-reproach. An attempt should be made to distinguish between statements that appear to reflect genuine feelings of remorse for the misconduct that did or could have hurt someone else and statements that are primarily intellectualized and reflect attitudes (e.g., socially desirable responses or genuinely held but strictly intellectual statements about "feeling bad"), or primarily regret for the negative personal consequences associated with the misconduct.

Ratings:

0 - No or Minimal Need
Individual genuinely appears to feel remorseful for engaging in the sexual misconduct. Understands and truly appreciates the negative effects of the sexual misconduct on others and is disgusted or appalled by having acted in this manner. Remorse is experienced at an emotional level and is expressed or demonstrated without prompting.

1 - Moderate Need.
There is some degree of regret and guilt; however, there are possible egocentric motives for these expressed emotions (e.g., shame or embarrassment, to avoid expulsion from school or criminal justice consequences). Score 1 when the remorse appears to be experienced at a strictly intellectualized (thinking) level rather than being associated with emotion.

2 - Significant Need
There is little or no evidence of genuine remorse or regret for the sexual misconduct or the harm or possible harm done to victims/survivors and others who may have been affected by such behavior (e.g., friends, family, and other victims/survivors or members of the campus community).

ITEM 6: VICTIM IMPACT / EMPATHY

Description:

This item assesses the individual's capacity to fully understand and appreciate, at an emotional level, the impact the sexual misconduct may have on the victim and others who may be affected by such behavior (e.g., friends, family, other victims/survivors, or members of the campus community). An attempt should be made to distinguish between statements that appear to reflect genuine empathy and those that are primarily intellectualized and reflect limited understanding or appreciation of the impact sexual misconduct can have, as well as statements and behavior that may suggest self-serving attitudes (e.g., socially desirable responses) or callous disregard.

Ratings:

0 - No or Minimal Need
Appears to express an empathetic understanding of the impact sexual misconduct has and can have on victims/survivors and others who may be affected by the misconduct. Statements and behaviors suggestive of victim empathy appear to genuinely reflect an emotional understanding of the negative effects of sexual misconduct, as well as feeling distressed for the actual or potential harm caused by engaging in such behavior.

1 - Moderate Need.
Expresses a rudimentary, intellectualized understanding of the impact sexual misconduct has and can have on victims/survivors. There may be some emotional appreciation of the actual or potential harm done, however this level of emotional understanding is limited or is evidenced inconsistently.

2 - Significant Need
Evidences little or no awareness or appreciation of, or concern about, the impact or potential impact of sexual misconduct. May evidence callous disregard for the welfare of others.

ITEM 7: BEHAVIORAL SELF-REGULATION

Description:

This item assesses the person's ability for self-control and self-management of behavior by being able to respond appropriately without reacting rashly or impulsively, as may be evidenced by a pattern of unsound, capricious, hasty decisions without consideration of their consequences. Behavior problems may include such things as (1) rule breaking and law violations, including delinquency or criminal charges, and school behavior problems in high school or college, (2) significant risky and impulsive behavior, such as reckless driving or driving under the influence, (3) repeatedly and hastily entering into intimate relationships that are inept and result in unwanted, unhealthy or regrettable relationship outcomes, and (4) frequent and/or excessive substance use. Appropriate self-regulation will involve exercising good judgment and age-appropriate problem-solving skills, thinking of implications and/or consequences, considering options, and acting accordingly.

Ratings:

0 - No or Minimal Need
During the past six months, behavior generally appears well controlled and managed effectively and without significant impulsivity. For example, school records and other available reports are free of references to impulsive behavior problems such as those described above.

1 - Moderate Need.
During the past six months, the individual has had occasional minor problems with impulsive behavior, but generally exercises good behavior control behavior and manages impulses appropriately. If there have been significant problems with impulsive behavior in the past, a Rating of 1 may be used to reflect recent improvement, as indicated by increased behavior management skills and behavioral control.

2 - Significant Need
There have been significant and/or long-standing problems with behavior regulation as indicated by multiple instances of impulsive or poorly controlled behavior, including behavior problems in high school and/or college, such as those exampled in the above item description. Sanctions for conduct problems other than the instant sexual misconduct, within the past six months, *may* warrant a rating of 2.

ITEM 8: EMOTIONAL SELF-REGULATION

Description:

Emotional self-regulation concerns the ability to identify, express, and effectively manage feelings, particularly in stressful situations or challenging circumstances. For example, when emotionally self-regulated, the individual is able to evaluate feelings accurately, manage and control emotions appropriately, and respond effectively, even in emotionally charged situations. In contrast, emotional dysregulation involves difficulties identifying, expressing, and managing emotions adequately or effectively, as may be exampled by losing emotional control (e.g., yelling and screaming), engaging in vitriolic arguments, acting impulsively, instigating physical altercations, and impulsive responding when distressed or angry. In contrast, some individuals may passively withdraw, sulk, and brood, and not express or discuss upsetting topics or other strong emotions, and some may turn to substance abuse or self-harm. Passive withdrawal may sometimes include standing by when others engage in harmful and/or sexually abusive behaviors. Problems with emotional dysregulation can contribute to difficulties in friendships and other interpersonal relationships, and may contribute to engaging in property damage or assaultive behavior, receiving official sanctions or warnings, or legal system involvement.

Ratings:

0 - No or Minimal Need
No significant incidents involving emotional dysregulation have occurred within the past six months (excluding the sexual misconduct referral). Appears able to express emotions appropriately and act accordingly and responsibly. If faced with difficult circumstances, has demonstrated the ability to deal with frustration or conflict without becoming unduly upset, argumentative, destructive, or aggressive.

1 - Moderate Need.
Had occasional but infrequent emotion regulation problems during the past six months. Is usually able to handle frustration or conflict without undue upset, temper outbursts, and resorting to extended, angry arguments, or destructive or harmful behaviors. If there have been significant problems with emotion regulation in the past, a rating of 1 may be use to reflect recent improvement as indicated by increased emotion management skills, and progress in managing emotions in stressful situations.

2 - Significant Need
Has a longstanding history of significant problems regulating or controlling emotions, including during the past six months. Emotional dysregulation may have contributed to problems with friendships, interpersonal relationships, physical fights, partner violence, or significant property damage, and official sanctions including warnings. Conversely, problems with emotional regulation may involve significant passive withdrawal in the face of strong emotions and involve substance abuse or self-harm. Passive withdrawal may include standing by when others engage in harmful and/or sexually abusive behaviors.

ITEM 9: ALCOHOL USE AND ABUSE

Description:

Excessive alcohol use (i.e., drinking to the point of intoxication) disinhibits unwanted, inappropriate, and occasionally offensive behavior, contribute to poor judgment and bad decision-making, and stimulate libido. It also may result in vomiting, passing out, accidents, and hangovers. It is because alcohol abuse is a significant factor in campus sexual misconduct that this item focuses on the individual's use of alcohol. Recent or continuing problems associated with alcohol abuse include, but are not limited to, sexual misconduct as well as other problem behaviors, such as missing classes, not completing homework, a drop in academic performance, difficulties in intimate relationships, friendships, and family relations, physical illness, blackouts, work related problems, driving violations, school sanctions, and legal difficulties. Other indicators of significant problems may include prior or recent referrals for substance abuse counseling, alcohol or possibly other substance abuse diagnoses, and drug court involvement. Occasional intoxication that does not impact health and functioning is common for this age group. When assessing the presence of problems associated with alcohol use and abuse consider the impact of alcohol consumption on functioning and well-being across multiple domains, such as school, employment, and relationships.

Ratings:

0 - No or Minimal Need
No or occasional use or abuse and no or minimal problems associated with abuse (e.g., a couple of instances of drinking to excess and, perhaps experiencing a hangover the next day and skipping a morning class). No notable problems with alcohol use in the past six months.

1 - Moderate Need.
More than minimal or occasional use and abuse within the past six months, drinking may include periodic weekend "binge" drinking or drinking to excess multiple times a week, and experiencing some problems associated with alcohol use, such as those described in the item description above. For example, the individual may drink alcohol to excess at parties and/or at bars on weekends, and may engage in drinking games and competitive drinking. Or, the individual sometimes drinks excessively when alone, perhaps to assuage feelings of loneliness or stress. If there have been significant problems with alcohol abuse in the past, a rating of 1 may be used to reflect recent improvements as indicated by sobriety or reduced alcohol use in recent months and an increased use of risk management skills for preventing problem drinking and alcohol abuse. However, if there have been no notable problems with alcohol use in the past six months interventions focusing on alcohol abuse may not be needed at this time and this item may be rated a zero (0).

2 - Significant Need
Alcohol abuse has been frequent and persistent in the past, including during the past six months, for example, as indicated by daily or periods of daily use, regular binge drinking at parties and bars where drinking

games and competitive drinking are common, and/or frequently drinking when alone. Alcohol use may be associated with multiple problems such as those discussed in the item description above. A rating of 2 may be appropriate when the individual has engaged in moderate or periodic alcohol abuse during the past six months, but there is a longer history of frequent, significant, and problematic alcohol abuse.

ITEM 10: SOCIAL ORIENTATION AND ENGAGEMENT

Description:

This item concerns the individual's social orientation and allegiances as reflected by expressed attitudes, values, and behavior regarding societal customs, rules and laws, social groups, and affiliates during the past six months. For example, an antisocial orientation may be indicated by a pattern of disrespect for authority, a belief that rules do not apply to the person or associates, and/or a pattern of rule breaking behavior, which may be indicated by school sanctions and juvenile or criminal justice involvement. In contrast, a prosocial orientation may be evidenced by expressed values and beliefs that are consistent with societal norms, associating with people and peers that are generally prosocial, volunteering in campus activities, social and environmental causes, or religious or cultural organizations. Some individual may evidence conflicting or mixed allegiances and associations. An asocial orientation may be indicated by an absence of social bonding, ties, and affiliations.

Ratings:

0 - No or Minimal Need
Individual evidences attitudes, values, and behavior consistent with a generally prosocial orientation. There is no apparent history of rule-breaking behaviors in the past six months.

1 - Moderate Need.
The individual currently expresses some attitudes supportive of anti-social behavior, such as an occasional disregard for certain rules or defiance of authority. However, the individual also evidences some attitudes, values, and behavior consistent with a mostly prosocial orientation. There may be some history of minor rule breaking that may have involved disciplinary action at an educational institution during the past six months (excluding the referral misconduct). Rule violating behavior is typically limited to peer-involved situations and is peer influenced. In the absence of behavior suggesting an antisocial orientation, an asocial orientation may be rated as a 1 because the absence of social bonds, ties, and associations may increase the risk of sexual misconduct as the individual seeks to get sexual urges met in sexually inappropriate ways, whereas prosocial attitudes, values, and ties may protect against such behavior.

2 - Significant Need

Individual frequently evidences attitudes that support anti-social behavior, such as defiance and disregard for authority, the encouragement of breaking rules and laws, and expresses the belief that society's rules do not apply to the individual, affiliated peers, or other associates. Antisocial attitudes are reflected in substantial rule breaking, including serious law violations (e.g., behaviors that could be legally charged, not including the instant student conduct referral), and that may have resulted in disciplinary action at an educational institution or legal charges during the past six months. Also use a rating of 2 at intake if there is a history of serious rule breaking or law violating behaviors that preceded college or that extends further than the past six months that may have included disciplinary action at an educational institution or legal action. Rule violating behavior is not limited to peer-involved situations. If, however, current attitudes and values do not appear consistent with an ongoing antisocial orientation, and if there has been no recent (past six months) history of ongoing rule violations, this item may be scored a 0 or 1, in spite of the past rule or law violations (e.g., a juvenile legal charge from years ago).

ITEM 11: SOCIAL COMPETENCE

Description:

This item concerns the individual's cognitive, social, and emotional skills for developing and maintaining mutually rewarding, respectful and healthy interpersonal relationships in multiple domains, (e.g., with peers, in intimate relationships and at school, work, and so forth) as evidenced during the past six months. Social competence includes the individual's knowledge, abilities, and use of respectful and appropriate "courtship"/ dating rituals, as well as skills for developing consenting sexual relationships. Deficits in social competence may be reflected by limitations in interpersonal skills that leave the individual socially uncomfortable, apprehensive, unassertive, and unassured around peers and possibly others. As a consequence, the individual may be highly vulnerable to social pressure and influence by negative peers who the individual seeks to impress, as well as inappropriate subcultural norms, such as those that promote non-consenting, disrespectful or aggressive interactions, such as may be present in some social organizations/fraternities or sports teams. Conversely, social competence may be lacking if the individual attempts to influence or control others, for example by recruiting them to engage in inappropriate behavior.

Ratings:

0 - No or Minimal Need

Individual appears to have cognitive, social, and emotional skills that are developmentally (age) appropriate, including the ability for engaging in mutually rewarding and respectful friendships and intimate relationships, and typically does so. The individual is able to utilize independent judgment, avoiding negative peer influences either as a leader or follower.

1 - Moderate Need.
The individual has some difficulties developing and maintaining mutually rewarding, respectful, and healthy interpersonal and intimate relationships. Social anxiety may restrict the individual's ability to establish and maintain positive, mutual relationships. Histories of maltreatment, loss, and/or rejection may interfere with developing trusting relationships. Social and dating skills may be limited and may also interfere, as might emotion and behavior regulation problems (Items 7 and 8). There may be a history of following negative peer influences or negative subculture norms, although occasional independent thinking may facilitate positive relationships.

2 - Significant Need
The individual has significant difficulties developing and maintaining mutually rewarding, respectful, and healthy interpersonal and intimate relationships. Significant social anxiety and difficulties trusting others may result in frequent social isolation. Significant emotional and/or behavioral regulation difficulties, including anger management problems, may disrupt friendships and intimate relationships. Strong dependency needs or passivity may interfere with making good, independent judgments in a manner that fosters mutual, respectful, and healthy relationships. If there is a history of allowing negative peer relationships to influence decisions to engage in significant misconduct or, conversely, attempts to influence others to engage in highly inappropriate behavior sexual or otherwise, but such behavior has not occurred within the past six months, a rating of 1 or even 0 may be considered.

ITEM 12: PEER RELATIONSHIPS

Description:

This item assesses the nature and quality of peer relationships during the past six months.

Ratings:

0 - No or Minimal Need
Individual appears to have developmentally appropriate, mutually rewarding, prosocial peer relationships. Associations include at least one close friendship; someone with whom significant personal details are shared.

1 - Moderate Need.
The individual appears to have one or more developmentally appropriate, prosocial peer relationships, however these relationships are more casual than close friendships (i.e., they do not appear to involve sharing significant personal details). Peer relationships may include associating with individuals and groups that encourage "partying," competitive drinking, and risky sexual behavior, including sexual conquests and/or a

pattern of periodic, but significant tension, strain, and conflict in peer relationships that may sometimes include physical fighting. These associations may involve occasional rule violating behavior, including nonviolent criminal offenses.

2 - Significant Need
Interpersonal relationships are limited, and/or fraught with tension/fighting, and/or problems. Relationships generally lack mutuality and/or equality, and some elements of misogyny, antagonism, and hostility may be evidenced in actual or reported comments or behavior. The individual may associate primarily with a peer group that encourages frequent "partying," pro-rape attitudes, sexual harassment, and sexual conquests. This negative peer group also may encourage and engage in bullying and aggressive behavior toward those they perceived as different from themselves, and may also engage in rule violating behavior (e.g., destruction of property), or other nonviolent and violent criminal behavior. Alternatively, the individual may be socially withdrawn and isolated from developmentally appropriate, prosocial peers and associates are acquaintances, not friends.

ITEM 13: INTIMATE RELATIONSHIPS AND SEXUAL BEHAVIOR

Description:

This item concerns the quality of one's intimate relationships, presently and previously. It considers a range of relationship attributes, such as sharing thoughts, feelings and experiences, and an emotional connection with a partner as well as sexual intimacy. Emotional and sexual intimacy is markedly contrasted with an apparent preference for uncommitted, impersonal sexual encounters that serves as the primary objective of the relationship, and which may be considered a "life choice" for now and the future. This seeming life style preference should be contrasted with a desire for freedom at this stage of the person's development, or simply the result of a lack of ability and social skills for engaging in a more committed intimate relationship.

Ratings:

0 - No or Minimal Need
If engaging in sexual behavior, consensual sexual behavior appears to be the norm and generally occurs within an ongoing relationship. Individual has a history of one or more developmentally appropriate long-term romantic relationships (i.e., 6 months to a year or longer) involving an emotional connection that includes friendship and non-sexual affection, and possibly sexual intimacy. If hookups occur, they are clearly mutually agreed upon and consensual.

1 - Moderate Need.
Individual has limited experience with intimate relationships that include emotional connections and friendship. Intimate relationships may be limited to relatively short-term relationships or occasional

dating that may include sex. Communication skills, social anxiety, and fears of rejection may interfere with developing a deeper and more satisfying emotional connection with a partner. The individual may occasionally engage in mutually agreed upon hookups possibly while involved in an ongoing intimate relationship and unbeknownst to the primary partner.

2 - Significant Need
Intimate relationships may be brief, lack mutuality, and often are problematic. They may be characterized by distrust, antagonism, and hostility. Sexual behavior may repeatedly occur indiscriminately outside the primary relationship. Uncommitted, impersonal sex with new acquaintances or others, in the absence of any ongoing emotional intimacy may be preferred to a committed relationship involving an emotional connection with a partner. This preference is not a result of a developmental stage when someone simply wants to be free from committed relationships for the time being. Such a preference may reflect someone's personality style or result from a lack of ability and skill necessary for engaging in a more committed intimate relationship.

ITEM 14: MENTORS OR OTHER PROSOCIAL SUPPORTS

Description:

This item addresses the availability and appropriate use of positive supports that foster healthy, respectful interpersonal relationships, help promote positive values, and facilitate prosocial development. Positive and prosocial support and guidance may be provided by various individuals, including parents, other adult family members and family friends, teachers, school administrators, coaches, employers, religious leaders, a therapist, a counselor, or student conduct staff, and also through participation in organized community activities that value and encourage respectful relationships.

Ratings:

0 - No or Minimal Need
The individual has a least one strong connection with a prosocial support, and uses this, or additional supports when stressed, or at other times of need. Positive supports are maintained and/or developed over time.

1 - Moderate Need.
The individual has some positive supports, but support may be limited or not consistently available or the person may be inconsistent in accessing and using these supports at times of need.

2 - Significant Need
The individual has no or few known positive supports, may be reluctant to develop such supports, or fails to use

those supports that are available. The individual may be judgmental, critical or rejecting of supports that are deemed positive, “healthy” or prosocial.

ITEM 15: OTHER (OPTIONAL)

Description:

Item 15 provides the option of noting additional risk factors and treatment needs that may be relevant, such as a psychiatric consult for medication if indicated, or substance abuse evaluation for drug abuse.

STARRSA TREATMENT PROGRAM

SEMI-STRUCTURED INTERVIEW GUIDE

Introduction:

This semi-structured clinical interview guide is intended for use during the brief intake assessment for the STARRSA treatment program. It is designed to gather relevant information that can help facilitate completion of the Risk & Needs Inventory (RNI) and enable the clinician and client to identifying appropriate treatment needs and develop an individualized treatment plan.

To help achieve these objectives, this semi-structured interview suggests assessment topics and a few focused questions that may be useful. The relevance for items on the Risk & Needs Inventory (RNI) are noted as well. Not every section in this guide will be relevant for an individual client and **not every question will need to be asked**. In fact, suggested interview questions are simply that, suggestions. If it is clear that some items, for example Alcohol Abuse, are not relevant for a particular client, those questions can be passed over or only minimally touched upon.

Space is provided for brief "Observations" (or notes) after each section, although arrangements for additional note-taking is recommended.

Demographics:

Asking basic demographic information, including current school status, living situation, and a brief overview of daily/weekly activities may serve as an icebreaker and also provide a foundation for risk relevant follow-up questions later in the interview.

Reason for Referral

(Possible RNI relevance for Items 1, 2, 4, 5 & 6)

Although additional questions about the sexual misconduct referral may follow once an initial working alliance has been formed, the following questions may provide some initial information about 1) the extent to which the client assumes responsibility for being sanctioned for sexual misconduct contrasted with blaming the victim, others, or situational factors, 2) expose attitudes and beliefs that support sexual misconduct, 3) indicate

feelings of remorse and sorrow, and possibly awareness and understanding of victim impact and empathy, and 4) help identify possible supports, negative influences, or rejection and isolation.

- **What led to you being referred for this treatment program?**
- **How do you feel about the complaint, the adjudication process, or sanctions?**
- **Who knows about what happened? Friends? Faculty? Family? Others? How did they react? What is their response now?**
- **Now that you have learned a little about this program, what are your thoughts and feelings about participating?**

Observations:

Significant History

Family of Origin
(Possible RNI relevance for Items 4, 14 & 10)

A brief family history may help identify and understand current attitudes, feelings and behaviors, attachment styles and relationships, as well as possible supports or stresses.

- **Who made/makes up your family? Were there any significant changes over the years (e.g., significant separations, additions)?**
- **How did family members get along?**
- **How did people in your home show emotions (anger, sadness, affection, disappointment)?**
- **What challenges did your family or family members face, (e.g., psychiatric history, substance use/addiction, domestic violence, problematic sexual behavior, criminality, child welfare involvement)?**
- **How would you describe your parents/caregivers attitudes about sex, partnerships, marriage, and gender roles? What religious or cultural factors may have influenced these beliefs?**

Observations:

Education / School Adjustment (Elementary – High School)
(Possible RNI relevance for Items 3, 4, 7, 8, 9, 10, 11, 12 & 14)

A brief educational/school history may help identify risk factors, such as school behavior problems and protective factors (e.g., positive school engagement), as well as information about learning style and challenges that may need to be addressed in treatment.

- What do you recall most when you think about your school years before college (e.g., what did you enjoy? What helped you learn? What did not? What kinds of grades did you get? Did you receive extra help (learning difficulties, special classes))?
- How did you get along with teachers, coaches, other adults at the school (Favorites, Mentors)?
- How might some of your teachers or other school personnel describe you? (e.g., A great student or athlete; positively involved in extra-curricular activities; a self-starter, leader, or follower; a trouble-maker or rule-violator?)
- How would you describe your behavior at school (engaged and positively involved, mixed, problematic)?
- How often did you get in trouble? What types of things got you in trouble? What happened?* How often did you skip school? What did you do instead? How often did you get detentions? How many times were you suspended from school? Were you ever expelled?

Observations:

College Transition

(Possible RNI relevance for Items 2, 3, 4, 7, 8, 9, 10, 11, 12, 13 & 14)

A brief review of the client's experiences transitioning to college may help identify situational factors that could be relevant to the instant referral and/or treatment progress, as well as protective factors and positive supports and influences.

- Please describe your experiences transitioning to college (e.g., managing your schedule, free time, feeling/managing stress, anxiety, depression, or homesickness or missing someone special at home). How are you managing the easy availability of alcohol and drugs and lack of parental supervision?
- What types of activities do you participate in with others at school (e.g., meeting up informally or engaging in more structured activities such as clubs, intra-mural sports, music groups, or social, political, or religious organizations, and/or more informal activities and possibly risky ones, such as clubbing, bar hopping, and partying, pre-drinking before going out to save money, and competitive drinking).
- How would you characterize your new acquaintances and friends? What do you like about them? What do you like to do together? What attitudes and beliefs do you share? Conversely, what attitudes and beliefs don't you share? Are there things you don't like about them? Have you made any really close friends? How is that going?
- If a student athlete, how are you treated as a new team member? Has there been an initiation process? What has it involved?
- Did you rush for or pledge to a sorority or fraternity? What was involved? Are you a member now? What do you like about it? What don't you like?
- How is dorm life? What has gone well? What not so well?
- Other than the current complaint, have you had any other student conduct reports or problems?
- What are your educational goals? What do you need to do to achieve them?

Observations:

Employment (if indicated)
(Possible RNI relevance for Items 7, 8, 9, 11, & 14)

- What job opportunities have you had? How did you get along with your bosses and co-workers? How might they describe you?
- Were you ever fired from a job? What happened?
- What are your vocational/employment goals? What do you need to do to achieve them?

Observations:

Military Service (if indicated)
(Possible RNI relevance for Items 7, 8, 9, 11, 12, & 14)

- How did you get along with your superiors and the other troops? How might they describe you?
- What type of discharge did you receive?
- Are there any bad conduct report, have you received any articles? Were you involved in with any UCMJ (uniformed code of military justice) process?
  - What types of bad conduct reports for you are on file?
  - What articles did you receive?
- Did you receive any medals, awards, or other achievements?
- How has the transition to civilian life been? How have you managed / succeeded?

Observations:

Peers
(Possible RNI relevance for Items 2, 7, 8, 9, 11, 12, & 14)

These questions may help identify the nature and quality of peer relationships (e.g., are those mentioned really friends or just acquaintances, are they positive or negative influences/peers, and so forth).

- Looking over your life, who have been/are your best or closest friends (first names only)? (What made you close? What did/do you do for fun or to pass the time? What types of things did you talk about? Did you ever get in trouble together? What happened? What do/did or didn't/don't you like about them? If the person or persons were childhood friends, are you still close? If not, what happened? How have your friendships changed overtime?)
- As you look over your life, are most of the people you know acquaintances, associates or casual friends (e.g., drinking buddies), or close or best friends? Who (first names only) could you share personal things with? How available are they now?
- How many of your current associates or friends have been in trouble with the law (A few, some, lots)?
- Have there been or are there times when you have problems socializing with peers or making friends? How do you feel at these times? How would you like it to be different?
- Relationships are stressful at times. How do you manage conflicts with your peers? How are conflicts resolved usually (e.g., brushed over and not talked about, arguing and yelling, physical fights, silently brooding, taking time to talk things out)?
- How much time do you spend alone (What do you do? Do you like being alone? Would you rather be with others or prefer this alone time)?
- Who can you count on? Who has your back? Who do you turn to for support?

Observations:

Mentors or Other Prosocial Supports
(Possible RNI relevance for Items 10 & 14)

- Which adults would you describe as important influences on your life? Are they still available and involved in your life (e.g., family members, family friends, other adult friends, teachers and authority figures outside of the family)?
- Are there adults who you currently turn to for support, advice and/or mentoring?

Observations:

Nonsexual Behavior Problems and Attitudes and Beliefs
(Possible RNI relevance for Items 2, 4, 6, 7, 8, 9, 10, 11, 12, & 14)

Consider instances of and especially persistent patterns of violating major rules (e.g., serious motor vehicle violations, such as reckless driving and driving while intoxicated, destruction of property, burglary and robbery, assaults, and problematic sexual behavior), and attitudes and beliefs that may support such behavior.

- All people break rules sometimes, when you were little (even prior to age 10), what types of rules did you break? How often were you in trouble for breaking rules?
- What about when you were older, middle or high school age? (Use same prompts)
- While growing up, how often did you get into physical fights or other conflicts with others? What happened? How were they resolved?
- Have you ever needed to show someone who was the boss, even when it required using force or aggression (i.e., bullying, coercion, and aggression)?
- How old were you the first time you broke a law? What type of trouble did you get in?
- How old were you the first time you were charged with a crime? What type of trouble did you get in?
- How many times have you been charged or arrested for an offense? What were the charges? What resulted (e.g., charges dismissed, diversion, probation, or incarceration)? If diverted or on probation, were these sanctions successfully completed or were they revoked due to violations (e.g., non-compliance with mandatory treatment?) If incarcerated, for how long and how did they fare (e.g., rule infractions and institutional disciplinary consequences and/or new charges, fights and assaults, etc.)?
- When you think about getting in trouble with the law in the past, how do you feel about it now? Who did your legal troubles affect and how?
- Why do you think people get in trouble with the law? Why do you think you got into trouble?
- What can people who have been in such trouble do to stay out of trouble?
- What do you want to do to keep out of trouble (What do you do now? What other plans do you have?)

Observations:

Personal Maltreatment History
(Possible RNI relevance for Items, 1, 2, 4, 6, 8, 9, 10)

Clinician Note: A reminder about mandatory reporting before covering this section is recommended. If a person maltreated the client when the client was a child, and the person is identifiable, a mandatory report may be required.

- Whether at home or somewhere else, has anyone touched you in a way that made you feel uncomfortable? What happened?
- Has anyone bullied you, physically pushed you around, or battered you? How often have you observed or experienced physical violence, and in what contexts, (e.g., parent figures, peers, gangs, community violence, partner abuse)?
- Were there times your parents or caregivers had trouble providing for you and any siblings basic needs (e.g., food, clothing, medical needs, shelter)? How were caregivers supportive and nurturing? How often were they unavailable, aloof, dismissive, or belittling and emotionally hurtful?
- What unwanted sexual experiences occurred? How old were you? What happened? (Touching? Penetration?) How old was the person who initiated the behavior? What was your relationship? How often did it happen, for how long? Were there other people who did this to you? (Same questions). (Same questions).
- How did this/these experience/s affect you? How often do you think about this/ these experience/s? How do you think it/ they affect you now? [Possible relevance for Item 1 or possibly Item 4 if it is used as a justification for abuse, e.g., *"It happened to me so it is okay for me to do it too"* or Item 6, *"It is no big deal,"* additionally, if traumatic stress symptoms are triggers, trauma focused intervention may be required before or concurrent with STARRSA treatment (Item 2 & 8)]

Observations:

Alcohol Abuse

(Possible RNI relevance for Items, 1, 2, 7, 8, 9)

Alcohol use and abuse is a risk factor for sexual misconduct on campuses. Drug abuse may be a concern for the client's overall well-being and functioning, but with the exception of administering alcohol to facilitate sexual contact and date rape drugs, it appears to have little direct association with sexual misconduct. Drug use could, however, impact treatment engagement, school involvement, healthy relationships, and other factors that may protect against sexual misconduct. Thus, a brief review of the client's drug abuse history and current usage may be important and if a treatment need, may be rated on Item 15. . Substance abuse screening tools such as the CRAFFT or MAST may be useful, if indicated, e.g.: http://www.ceasar-boston.org/CRAFFT/index.php; https://ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf

- Please describe the role alcohol has had in your life, particularly during the past 6 months [e.g., frequency, situations (with others/alone), amount and duration; when and where, type of use, binge or steady use), need for increased quantity to achieve the same effect (tolerance), felt urges or need to drink (dependence) as well as periods of abstinence, longest period of sobriety]?
- How did transitioning to college affect your alcohol use?
- How does alcohol change your emotional state or help you cope, (e.g., as a stress or tension release, that is, to relax, reduce social anxiety and facilitate sociability and fit in) or to manage unpleasant feelings like depression, sadness, loneliness, anxiety, anger or resentment, or when just feeling "bad" or "bad" about yourself?
- What risky behaviors have you engaged in while intoxicated (e.g., competitive drinking, driving under the influence or with others who are intoxicated, going off with people you just met and know nothing about, and/or unintended and/or unprotected sex while intoxicated, sexual misconduct).
- Have there been times, when you cannot remember some of what you did when you were drinking, (e.g., nod out or blacked out; found yourself somewhere but did not know how you got there, or woke up to find yourself with bruises but had no recollection as to how you got them)?
- How often did/do your college friends get together and drink or "party," engage in competitive drinking and/or drink to excess? How frequently are parties seen as opportunities to facilitate sexual encounters? How often are drugs available to make it easier to have sex with women at the party?
- What negative consequences have you experienced as a result of alcohol abuse e.g.,
    - Relationships: (e.g., difficulties in friendships, intimate relationships, and family relations; unintended sex while intoxicated; unprotected sex while intoxicated).
    - School related: (e.g., not completing homework, missing classes, lower than usual grades,

alcohol related student conduct report/sanction, referred for substance abuse treatment?).

- Work: (e.g., gone to work hungover, missed work due to drinking, lost job)
- Financial: (e.g., excessive spending on alcohol, losing track of finances).
- Health: (e.g., hungover, physical illness, sexual transmitted infection, blackouts, substance abuse or dependence medical diagnosis and treatment referrals).
- Legal Violations: (e.g., operating under the influence, minor or more serious criminal offending arrests ranging from trespassing to serious assaults, including sexual misconduct, and concomitant related legal problems).
- Other personal troubles, such as feeling embarrassed, disappointed, ashamed of oneself.

- What would you like to change about your alcohol use or alcohol-related behaviors?
- Have you ever participated in alcohol or other substance abuse treatment? When? How did it go? What was helpful? What wasn't?
- Although we are not focusing on drug use today, do you think a similar review of your drug use and/or a referral for alcohol or drug treatment would be useful?

Observations:

Psychological and Behavioral Functioning
(Possible RNI relevance for Items, 2, 6, 7, 8, 9, 11, 12, 13, & 14)

- How do you manage the stresses of daily life?? How effective are these strategies? What else has been helpful? Would you like to learn new ones? How do you manage major crises? (Same prompts if indicated)
- In general, what do you do to manage strong upsetting or angry emotions? On a scale from 1-10 with one being none to very little to ten represented very much so:
  - How effective are these strategies?
  - What else has been helpful? How interested are you in learning other approaches?
- Everyone gets upset, sad, or troubled sometimes, what kinds of things get you upset?
  - What do you do when you are upset? (Some people withdraw and isolate, some become irritable, etc.)
  - How do you know when you are getting upset, sad, or troubled? How would someone else know you are upset?
  - During the past 6 months, have such distressing emotions been a problem for you or others (e.g., with friends, partners, family, teachers, bosses, etc.)?
  - During the past 6 months, how often has feeling sad or troubled interfered with your life? What happened? Have these emotions or troubles resolved? How?
- Everyone gets mad or angry sometimes, what kinds of things get you angry?
  - How quickly do you get angry? Would people say you have a short or long fuse?
  - How do you know when you are getting angry? How would someone else know you are angry?
  - What do you do when you are upset or mad (Some people throw or break things or push, hit or punch someone, some brood, or sulk)?
  - During the past 6 months, has your temper been a problem for you or others (e.g., with friends, partners, family, teachers, bosses, etc.)? Obtain details about when, where, and with whom.
  - During the past 6 months, how often has your temper caused a problem? What happened? How do you feel about that or those incidents now? If presented with the same situation, what could you do differently? What could you do now about what happened? What could you do to prevent or avoid such situations in the future?

Observations:

Treatment Service History

(Possible RNI relevance for Items 2, 7, 8, 11, & 14)

- Prior to college, were there times you or your family sought counseling or other mental health services for you or the family (e.g., evaluations, counseling, crisis services, residential treatment, psychiatric hospitalization, or medication)? If so:
  - What types of services?
  - If for you, what symptoms or problems were you having (e.g., attentional difficulties, hyperactivity, anxiety, depression, behavior problems)?
  - How frequent were these symptoms or problems; how long did they last (e.g., chronic, episodic, or resolved)?
  - Were any medical diagnoses suggested?
  - How old were you at these times?
  - What was helpful? What wasn't? What was the outcome of treatment?

(Repeat questions for each period of treatment, obtain provider contact information, if possible)

- Since coming to college, have you sought or received professional counseling or psychiatric help, excluding this student conduct referral? (Query as above regarding symptoms and diagnoses, types of treatment, utility and effectiveness).
- What current medications are you taking to help (i.e., name, dosage, duration, effectiveness, taken as prescribed)?
- Having reviewed mandated reporter responsibilities, ask: How often have you seriously thought about harming yourself? What precipitates such thoughts? What preparations have you made? What action have you taken? (i.e., assess suicidality, history and risk of self-injury, and harm to others)
- Who knows of these thoughts? How do they respond? Do you feel you have support when it would be helpful? Who do you turn to

Observations:

Sexuality, Sexual Behavior, and Sexual Relationships
(Possible RNI relevance for Items 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, & 14)

Remember when we began, I said I would be asking you some questions about sex? Please answer honestly. If you'd rather not answer a question, just say so. I'd much prefer that you not answer than not answer honestly.

- Sexual feelings and attraction
    - When did you first experience sexual feelings and urges? How did you manage these feelings? How old were you when you became sexually active?
    - How would you describe your sexual orientation and identity?
        - If the client endorses being gay or bisexual or transgender (if transgender, ask whether there is a gender they identify with and what pronoun they prefer. Also explore whether the client is comfortable and open about their orientation or identity, as well as harassment, bullying, abuse experiences and the availability of positive supports. Also, listen for and explore hostile LGBTQ attitudes among heterosexual clients that may surface in response to this question, and sometimes are associated with sexual misconduct).

People often have questions or concerns about their sexual thoughts, feelings, and behavior, I hope as we work together in treatment, you will feel comfortable raising any such concerns.

- Sexual activity
    - Teens and young adults often have sex on their minds; please estimate how many times you think about sex a day?
    - When do you experience periods of significant increased or decreased sexual desire, interest or activity? What was going on at the time? Were you feel more tense, etc. Note: For example, people sometimes masturbate or engage in sex with someone to change their emotional states, such as a tension release or coping strategy (i.e., to cope with negative feelings like depression, sadness, loneliness, anxiety, feeling "bad" about yourself, angry or resentful)? How has sex been useful for you in managing your moods?
    - Are there times when it seems sex is all you can think about? If you are in a situation when you cannot engage in sexual activity or masturbate, what do you do?
    - What functions or needs does sex fulfill for you? (e.g., sexual satisfaction, intimacy, fun, stress reduction, manage negative emotions).

- Pornography
    - People have many views about pornography, what are yours?
    - Continue if appropriate: What types of pornography do you like? (Ages? Genders? Violence?) (e.g., MILFS, Schoolgirls, S&M)
    - How many time a day do you look at porn / masturbate to it?

- When if ever, has pornography use/sexting be a problem (e.g., interferes with school, relationships, etc.) for you?

- Partners
  - On average, how often do you have sex? How does this compare with your desire for sexual activity, need? Enough? If not, why not?
  - How long do you usually know someone before having sex?
  - How often do you engage in sex with people you just met or "friends with benefits"? Note: If they say they do, ask: Under what circumstances (e.g., not while in an ongoing relationship, partying...)?
  - How often do you engage in sexual activities on the web (e.g., chat rooms, live Internet sex)?
  - What types of sexual encounters do you prefer (e.g., impersonal sex, such as prostitutes or Internet sex, casual sex, such as "friends with benefits", or sex in an intimate relationship)? What are their pros and cons?
  - What is your estimate regarding how many people have you had sex with? What are your thoughts/feelings about this number?
    - Any unintended pregnancies – children?
    - STDs?
    - Negative sexual experiences?
  - For what types of sex do you use a condom (oral, vaginal, anal) and how often (what percent of the time?)
  - Whose responsibility is it to ensure safe sex?
  - How else do you ensure safe sex? (e.g., ensure consent, the ability to consent)

- Sexual attitudes
  - When is it okay to expect someone to have sex with you (e.g., dating, previously have had sex, spent money on a date)?
  - When is pressuring someone to have sex really okay (e.g., when the other person shows interest, when you have been dating, etc., never)?
  - What is consent? Is it important? How do you get it? Who can consent? Can't?
  - What should women understand about sex? What should men understand?

Observations:

Sexual Misconduct

(Possible RNI relevance for Items 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

- Current Referral

  The following questions may help assess the extent to which the client currently assumes responsibility for the current instance/s of sexual misconduct (Item 1) as well as for thoughts, feelings, behaviors and circumstances that contributed to his/her behavior (Items 3 & 4). The step-by-step review of events leading up to, during, and after the misconduct can help identify situational and contextual factors that contributed to the misconduct and may be relevant for assessing social competence (Item 11) as well as negative peer influences (Item 12) and substance abuse (Item 9) as well as deleterious emotional states, such as jealousy, rage, and revenge (Item 8). The degree of impulsivity contrasted with forethought and planning also can be assessed (Items 4, 7, 10). The following questions also may help identify attitudes supportive of sexual misconduct (Items 4 & 10) as well as indications of remorse (Item 5), an understanding of victim impact as well as empathy for victims (Item 6), and appreciation of the wrongfulness, seriousness or gravity of the behavior (Item 5).
  Note: I just want to understand exactly what was going on with you leading up to, during and after the incident/s.

  - What types of sexual misconduct were you found responsible for?
  - Walk me through what happened, step-by-step, prior, during, and after the incident/s.
  - What do you recall thinking and feeling before, during, and after the incident/s?
  - What are your thoughts and feelings about what happened now

- Additional Allegations or Findings of Sexual Misconduct:
  - Has anyone else ever accused you of sexual misconduct?
  - Were you found responsible in a disciplinary hearing or adult criminal court?
  - Has anyone told you that you have problems managing your sexual behavior?
  - How interested are you in managing developing more ways to engage in healthy relationships and sexual behavior.
  - Has anyone said you have a sexual behavior problem? What have they said?
  - If violence was used to gain compliance, possibly note and ask: Some people find forcing sex sexually exciting. How much of a turn on was this for you? (Can ask them to rate on a 1-10 point scale with 10 being a lot).
  - Repeat questions, if multiple incidents

Observations:

Victim Awareness
(Possible RNI relevance for Items 1, 2, 4, 5, 6, 10)

Awareness of the impact of sexual misconduct on others would seem likely to deter a person from engaging in such behavior. Although this has not been demonstrated empirically, it make sound theoretical sense and is, therefore, included in this treatment curriculum.

- **What short and long-term consequences do you think may result when someone is exposed to sexual misconduct (e.g., during/after? How may it affect their lives?).**
- **How might others be affected (e.g., friends or family members, campuses, etc.)**
- **How did you feel when you learned the person filed the complaint against you? How do you feel now about the complaint?**
- **What do you think this experience has been like for the person who filed the complaint against you?**
- **If you were permitted to speak to this person, what would you like to say?**
- **Repeat questions, if multiple incidents**

People often have questions or concerns about their sexual thoughts, feelings, and behavior, I hope as we work together in treatment, you will feel comfortable raising any such concerns.

Observations:

Wrap up

(Possible relevance for Items 2, 7, and others)

- Please describe yourself in your own words (ask or point out strengths and accomplishments)
- What are your goals, hopes, and dreams?
- What about yourself and/or your life would you like to change? (What would you like to improve about yourself and what would you like to stay the same; that you do not wish to change?)
- What about yourself do you value, and want to keep?
- Since the incident, what if any, changes have you noticed about yourself, or in your behaviors?
- Given what you know now, what can you do to prevent any further complaints against you for sexual misconduct?
- On a scale from 1-10, with 1 being none to 10 being very much so, how confident do you feel you can make necessary changes (e.g., perhaps avoiding negative peer influences, lifestyles?)
- How interested are you in participating in this treatment program? What barriers do you foresee? What may be useful for helping you become engaged?

Observations:

APPENDIX F

Activities & Materials

Activities and Materials (Handouts and Worksheets)

- **Victim Impact Vignettes**
- **Attitudes and Beliefs Worksheet (Cognitive Distortions Worksheet)**
- **Experiential Exercises list (see flash drive for exercises)**
- **CERTS Handout (see flash drive and hard copies in packet)**
- **My Plan For Success**
- **Son It's OK if You Don't Get Laid Tonight**
- **Link to: How 7 Things That Have Nothing to do With Rape Perfectly Illustrate the Concept of Consent**
- **Sex and the Law Supplemental hand out**

PowerPoints

- **Sex and the Law**
- **Changing Times**
- **Drugs and Rape**
- **Groupthink**
- **Negative Masculinity**
- **Socio-cultural Context of Rape**

Multimedia Resources

- **All Program Videos by Treatment Modules**
- **STARRSA Program video descriptions including intro and outro narrations**
  - Note: The clinician may decide whether they want to play the outro or review this with the client directly.
  - STARRSA Program Videos are recommended to be used in session only.
- **Additional multimedia resources**

ACTIVITIES AND MATERIALS

Handouts & Worksheets

VICTIM IMPACT VIGNETTES

Select from the following vignettes (Note: some have harsh language content). Present and discuss the following vignettes. For each vignette, there are a series of questions that the clinician can ask the client after s/he reads the vignette. Do not give the client a copy of the questions. The clinician should ask the questions in session after the client reads the vignette. This can be a good exercise for the clinician to obtain a sense of level of empathy, perspective taking, and if the client's orientation/focus is on self or others. Take note of whether client's responses are cognitively focused and devoid of an emotional response (either the lack of emotional expression or discussion of client's emotional reactions and feelings). Make note of whether the client is able to identify the central issues/problems in these vignettes or instead identifies peripheral details as salient concerns.

VIGNETTE 1

You receive a phone call from your neighbor's sister who informs you that your neighbor was mugged and will be in the hospital for a few days. She is calling to let you know that he won't be able to keep his plans with you (i.e., you had asked him to help you tomorrow with a highly specific task). Unfortunately, he is the only one that you know of with the expertise required for this task.

Ask the client:

- What is your first thought?
  - Look for whether their immediate reactions are focused on self or victim. Look to see whether he eventually shows concern for the victim.
- What other thoughts/reactions come to mind?
  - Look for empathy, care, and concern for the victim/survivor.
- Would you have any questions/ask his sister anything?
- What would you say to his sister?

This vignette allows the clinician to start slowly and safely by using an example of a nonsexual, but physical transgression and provides a way to assess two key constructs:

1. Does the client have genuine, internally driven interest and concern for the welfare of others?
2. Does the client have empathy - the ability to take the perspective and feel what another person feels?

If the client is only focused on how the situation will impact him/her, and cannot display understanding or compassion regarding the more severe issue of his neighbor being severely harmed, this might be clinically relevant

Assess client's emotional capacity to continue with these exercises. If the client is too emotionally activated, discontinue after the 4th vignette, do not present vignette 5 or 6.

VIGNETTE 2

You find out that your sister (if the client does not have a sibling use cousin or known biological relative, but not the client's parents) was severely beaten by a man she was dating for 2 months.

Ask the client:

- What is your initial reaction to hearing this information?
  - Look to see if the reaction is cognitive or emotional.
  - Try to solicit client's verbalization of emotional reactions too.
- What would you do?
- What would you ask the person conveying this information to you?
- What would you want to see happen to the man to whom she was dating?
  - Look for emotional reactions towards the perpetrator.
  - Look for sense of fairness, compassion towards perpetrator.
  - Severe hostility and lack of compassion for perpetrator might be a reaction that the client is struggling with towards himself or his fear that others will have this reaction towards him.
  - Look for reactions that blame the victim, justify the violence. If these are encountered, consider revisiting topics from previous modules, or cross reference with work completed from prior related modules.

VIGNETTE 3

You meet your girlfriend/partner after work for a date and find that your partner is visibly distraught. You find out that your partner's boss called her/him in to her office and started complimenting her/him on her/his performance. Initially your partner was happy by the praise for her/his work by the boss (a male in his 50's). Then, your partner's boss started to compliment her/him on her/his clothing and physique. The boss gently and suggestively brushed her/his arm while telling her/him that s/he has a lot of potential and could really move up in the company. The boss stated that she/he can do this by unleashing that potential in another "cooperative way" and asked if she/he would we willing to discuss this over dinner and drinks this Friday at the bar in a local upscale hotel. Your partner's boss reminded your partner that his/her new employee review is coming up and he is certain that they will both benefit by "working together" to help each other "rise."

Ask the client:

- What is your immediate reaction?
- Other thoughts?
- How do you think your partner is feeling?
- What would you advise your partner to do, or say?
  - Does the client recognize that this is sexual harassment and the boss' comments and sexualized are inappropriate?
  - Can the client take the perspective of the victim (his partner) exclusively and separate it from his/her own perspective/feelings as the victim's partner?

VIGNETTE 4

You're playing basketball with your friend and he tells you that he's pissed off and you'll never believe what happened to him the other day. He tells you that while he was getting dressed after practice, another guy on the team came up to him from behind, grabbed his butt and then felt around and started stroking his penis. He reacted by throwing this guy against the locker and yelling, "What the fuck are you doing? You ever fucking touch me like that again; I'll shove your cock up your ass." He says that he's not sure what's more disgusting – the fact that someone thought he "swung that way" or the "fact that they're now letting homos on the team." He wants your opinion about what to do to get this "fag" off the team.

Ask the client:

- What is your reaction, thoughts?
- What do you say to your friend?
- How would you feel if this happened to you?
    - Look to see if the client can identify some of the problems with his friend's biased statements from topics covered in modules 3, 4 and 5.
    - Look to see if the client can identify that his friend was sexually abused.
    - Look to see his reaction to his friend's focus on getting this guy off the team because he is gay rather than because his behavior was inappropriate and a type of sexual abuse.
    - Use this as an opportunity to discuss/review that sexual abuse is not something that exclusively occurs in a male-female heterosexual context.

VIGNETTE 5

Your best friend calls you at 3 in the morning, crying hysterically. You can barely understand what she is saying but she tells you come and get her. She sounds very nervous and tells you that she saw Ken at a party (You know that she has casually dated Ken in the past and they have had sexual relations before). You're able to figure out, in between her crying, that they had a lot to drink and after she went to the bathroom upstairs, Ken grabbed her and started kissing her passionately. They started to move into a bedroom and continued making out. He was caressing her breasts and then started to take off her pants. She said to stop and pushed his hands away, but he continued. He threw her on the couch, pinned her down with one arm while kissing her and inserted his finger into her vagina with his free hand. She continued to struggle and managed to get him off of her. She headed towards the door and said she would report him. He blocked the door and said, "Are you fucking kidding me? You've never said no before and I didn't even get to shoot my load. Don't be a cock tease. Come on," He started to unzip his pants and grabbed her hand, pulling it towards his penis. She tried to resist. He said, "No one's going to believe you. We've already fucked before and you're totally wasted. You're not fucking going anywhere until I'm finished." He grabbed her, threw her down on the couch, pulled down her pants and penetrated her with his penis while choking her. She was starting to get dizzy and was having trouble breathing. She grabbed the lamp behind her and managed to hit him over the head with it and get away.

Ask the client:

- What is your first reaction?
- What do you say/ask your friend?
- What do you do?
- What do you think your friend is feeling at this moment?
- Do you have any concerns, worries?
- Does the fact that they had sex before change anything?
- How would you feel if you were dating her?
- How would you feel if this was your sister, a cousin, or another female that you loved?

VIGNETTE 6

You discover that a woman was attacked while she was out for a morning jog. The attacker hit her with a blunt object from behind. Although she tried to fight him off, he was quite large and physically strong and overpowered her. He punched her three times in the face, breaking her cheek bone. She will require multiple surgeries as a result. He then ripped her clothing off and penetrated her vaginally and then anally, and then hit her again, knocking her unconscious before fleeing the scene. She was discovered by another jogger.

Ask the client:

- What is our first reaction?
- Other thoughts?
- How do you think this woman is feeling?
- What do you think the appropriate consequence is for the attacker?
- What if this was your mother?
    - How would you feel, what would you do, would this change your answer about the consequences?

Ask the following questions:

- What do all of these vignettes have in common?
    - All victims were violated and/or harmed
- What do you think all of them felt? Try to see if there are common themes and differences.
    - Does the client possess a nuanced understanding of different emotions that might be experienced by these different victims and different resources and needs?
- What do these all have in common?
    - All had horrible things done to them, violations.

If the client says maybe they "deserved it, provoked it" use this to discuss some of the attitudes and thoughts that were challenged in the previous sessions. Differentiate between judgment, choice, and the lack of choice because someone violated and did something without that person's consent and the harm this caused.

If the client engages in victim blaming, discuss and provide psychoeducation to the client.

Review the Jogger vignette again and ask the following:

What services do you think the woman jogger will likely need?

- Physical:
  - Immediate medical attention
  - Surgery bills
  - Physical therapy
  - Brain injuries, broken bones and other physical trauma
  - Treatment for STDs/pregnancy
  - Long term medical needs?
- Psychological:
  - Fear
  - Trauma reactions/PTSD
  - Need for treatment
  - Avoidance
- Social/Lifestyle Disruptions:
  - Negative changes in interpersonal relationships (partner, children, other family members, friends, coworkers)
  - Negative changes in routine
  - Changes in prior social, work, school, social activities and interest
- Financial:
  - Hospital bills
  - Surgery bills
  - Physical Therapy bills
  - Bills for psychological treatment
  - Loss of work/time off from work

Ask the client: How much do think a sexual misconduct costs the average victim?

- It is estimated that each sexual misconduct costs the victim at least $87,000 a year for such expenses as:
  - Short term medical care $500
  - Health services $2400
  - Lost productivity $2200
  - Pain and suffering $80,000 - $104,900

What are the other consequences to victims?

- In addition to the outright costs, rape victims are at risk of suffering from many other problems .
  - 4 times as many will suffer an emotional breakdown
  - 25%-50% will suffer from lifelong physical consequences
  - Negative or unwanted changes in his/her sexual lifestyle

VICTIM IMPACT VIGNETTES

Many of our attitudes and beliefs about women and men exaggerated or false ideas that can justify and sustain unhealthy sexual behavior. The way we think and what we believe can have a profound impact on our feelings and on our behavior.

There are different types of such attitudes and beliefs, and they can serve different purposes. We have listed a few of these "purposes" below. One of the goals of therapy is to help the individual identify some of their own attitudes and beliefs. This is a core part of all programs for sexual misconduct.

Labeling – applying "labels" that are "negative" and that have no basis in reality. Virtually all cognitive distortions are basically broad "labels" that stereotype large heterogeneous groups, such as all women or all Muslims, or all African-Americans, or all Jews, etc. These labels are typically grossly distorted and serve only the purpose of harming the target by painting all members of the group with a single brush stroke.

Negative Filter – refers to the tendency to "filter" all input about the targeted group as negative.

Over-generalization – refers to a sweeping application of negative options and attitudes based on a single incident, thereby "generalizing" from one person or incident to a group.

"Shoulds" – interpreting events in terms how things should be or how people should behave based on preconceived notions, failing to recognize that the behavior may be entirely appropriate for a member of a "different" group.

Blaming – directing your animus, your anger, your resentment, your guardedness/suspiciousness at others as the primary source of your negative feelings rather than taking personal responsibility. In the case of sexual misconduct, it is called victim blaming.

Judgment Focus – making coarse negative judgments about the targeted group, referring to all group members are bad (as opposed to good), inferior (as opposed to superior), failures (as opposed to successes), lazy as opposed to ambitious, stupid as opposed to smart, weak as opposed to strong, etc. All members of all groups would fall along a normal distribution of such traits.

Numerous scales have been developed that tap a variety of beliefs, such as the adversarial nature of men's relationships with women, stereotypical ideas about sexual roles, negative ideas about masculinity, and rape myths that support sexual misconduct. Although these scales have typically been developed for research purposes, the presence of these attitudes and beliefs have been a mainstay in all treatment programs for both juvenile and adult sex offenders.

These attitudes often reflect deeply ingrained core beliefs about women, about sexuality, and about relationships that are fundamentally hostile, demeaning, and even degrading. These attitudes form the foundation of negative masculinity. As noted, these attitudes and beliefs are often deeply rooted and firmly held, because they have been – and continue to be – reinforced by a culture that supports such attitudes as normal; if these attitudes are "normal," they must, by definition, be okay – after all, it's what everyone else thinks, which is another distorted belief, because everyone does not. These attitudes are perceived as normal, since they are directly communicated by one's peers and occasionally first heard as a child when growing up. These same attitudes are indirectly communicated by the marketing and advertising industries, in professional sports, in movies, by many politicians and shock jocks.

In a meta-analysis examining 11 different measures of masculine ideology across 39 studies, Murnen et al. (2002) found that although all but one measure of masculine ideology were significantly associated with sexual aggression, the strongest support emerged for negative masculinity and hypermasculinity, both of which assess hostile beliefs about women, the need to be in control, and an acceptance of violence against women.

BROADER CLINICAL / INTERVENTION ISSUE:

It is necessary to address this artificial cognitive divide imposed by rigid conceptions of who "real" men are and who "real" women are. The same traits the student so admires in some "real" men, are clearly observable in some women, and those same traits are only minimally observable or absent in most men. There are roughly 120 million men in the United States and roughly 11,500 are Navy SEALS or Army Rangers. That translates to .000096 of the population of men (or about .01%)!

We only have heroic males in fictional roles because that package of traits we so admire are not present in the vast majority of men! We watch the fictional exploits of larger than life males like Arnold Schwarzenegger, Sylvester Stallone, Bruce Willis, Dwayne Johnson ("The Rock"), John Wayne, and Clint Eastwood take out the entire "enemy" single handed (with 1 hand tied behind their back). In real life, these are just actors no more capable of "taking out the enemy" than you or I. But watching them on TV or in a movie theater plays out all of our fantasies of unimaginable courage, bravado, and skill as combatants.

Even fictional "villains" (Godfathers) that represent these same hyper-masculine traits such as Tony Montana and Tony Soprano are revered. Consider the two famous Tony Montana quotes:
"In this country, you gotta make the money first. Then when you get the money, you get the power. Then when you

get the power, then you get the women."
"All I have in this world is my balls and my word and I don't break them for no one."

It's the swagger, the supreme "make my day" confidence, the façade of invincibility. These "real" men would be helpless if placed in the real circumstances depicted in their movies. By shrinking the rigid dichotomy of who "men" are and who "women" are we begin to overcome the "dis-similarities" that make women "strangers" to men. Strangers are dis-similar creatures that readily evoke myth. When we strip away those dis-similarities and see others as "familiar," and the myths become transparent as nothing more than myths. We don't create myths about our friends or those that are very familiar to us, only about those that we regard as markedly dissimilar.

The following Worksheets include two different types or categories of beliefs / attitudes: those reflecting negative masculinity (i.e., negative, unhealthy and erroneous beliefs about what it means to be a "man") and those reflecting rape myths and misogynistic views of women. These Worksheets should not be "attached" to this "Intro" above.

The Worksheets could be used as an exercise, but it is critically important that the student understand that:

1. They are NOT "graded" and there is no "score,"
2. They are intended for the student to reflect upon and discuss in session (e.g., which of these attitudes have you heard from your peers? your friends? at home growing up?, which of these attitudes sound "right" to you, as in make sense? are there some that you feel more strongly about? Perhaps for further discussion about the "origins" of these beliefs, where do they come from, how were they reinforced during my childhood my adolescence, and now in college; these Worksheets are intended only to get the student to think about these beliefs and discuss in session. Assure the student that the Worksheet is NOT to be turned in. It should be discarded (torn up, shredded if possible) in the office.
3. If these Worksheets are given to the student as an out-of-session exercise, they MUST be completed alone and not shown to or discussed with friends, roommates or anyone else. It would defeat the purpose to have the student sharing them with friends, saying "hey, get a look at this one! what should I say?"

ATTITUDES AND BELIEFS WORKSHEET: WOMEN

Read the following attitudes / beliefs below, and rate the degree to which each "rings true" for you, and the extent to which you have now or in the past believed them:

Statement/Thought	0 No Absolutely Not	3 Moderately, Sometimes	5 YES, Strongly
Accepting Responsibility for All Sexual Behavior			
When women wear short skirts or tight tops, they are just asking for sex			
Most reported rapes are false			
Women are good for only one thing			
Many women cry rape after regretting sex the morning after			
Women can be really manipulative			
Women can successfully resist a rapist if she really wanted to			
If a woman goes home with a man on their first date she wants to have sex			
Cock teasers get what's coming to them			
Nice girls don't get raped			

A woman who has sex on the first date is a whore	
Women typically don't deserve the same pay as men, even if they have the same job.	
There are some jobs that are just not for women	
If a woman gets drunk at a party and has sex with a guy she's just met, she should be considered "fair game"	
Women should take care of children and the house, not want a career	
Many women have an unconscious wish to be raped	
In most rapes, the victim was promiscuous	
Many women cause their own rape by the way they act and the clothes they wear	
Campus sexual assault has been blown out of proportion by women	
Most men that are accused of rape are really innocent	

Campus sex isn't rape because when women go to parties, sex is just part of partying	
If both persons are drinking then neither can be held responsible for a sexual assault	
Women like a tough, strong man who tells them how it is	
Women say no even though they really mean yes to sex	
Being roughed up is sexually exciting to many women	

ATTITUDES AND BELIEFS WORKSHEET: TOXIC MASCULINITY

Read the following attitudes / beliefs below, and rate the degree to which each "rings true" for you, and the extent to which you have now or in the past believed them:

Statement/Thought	0 No Absolutely Not	3 Moderately, Sometimes	5 YES, Strongly
I can take a beating as well as any man.			
When I have a drink or two I feel ready for whatever happens.			
Any man who is a man needs to have sex regularly.			
I've always wanted to have a really fast sports car.			
If you're not prepared to fight for what's yours, then be prepared to lose it.			
When women go braless and wearing short skirts and tight tops they are just asking for trouble			
I'd rather gamble than play it safe.			
I've been told I take foolish risks.			
A strong man never cries.			
It's natural for men to get into fights.			

Sometimes the only way a man gets a cold woman turned on is to use force.	
I like wild, uninhibited parties.	
I never let another guy get one up on me.	
I never let another guy get one up on me.	
Get a woman drunk, high, or hot and she'll let you do whatever you want.	
I tend to self-centered.	
There are times when a husband or boyfriend needs to discipline his wife or girlfriend.	
I never feel bad about my tactics when I have sex.	
I have destroyed things just for the hell of it.	
A lot of women seem to get pleasure in putting men down.	
A man should beat a guy who insults his woman.	
After I've gone through a really dangerous experience, I feel high.	
A woman will only respect a man who will lay down the law to her.	

I remind myself that I'm "number one" and have to look out for myself first.	
I like fast cars and fast women.	
I can hold my own with anybody when it comes to drinking.	
My needs come first.	
A lot of women seem to get pleasure in putting men down.	
I like to drive fast, right on the edge of danger.	
I've gone out with a lot of women.	
I work out with weights to keep my muscles in shape.	
Some women are good for only one thing.	
I'd rather gamble than play it safe.thing.	
Sometimes a man is justified in hitting his wife	
I would rather be a famous prizefighter than a famous scientist.	
I've thought about carrying a concealed weapon.	

When I'm bored I look for excitement	
Women appear to tell the truth, but I know otherwise	
Pick-ups should expect to put out.	

EXPERIENTIAL EXERCISES

The following experiential exercises are located on the accompanying flash drive.

Developed by Dr. Barbara Schwartz and adapted for the STARRSA program.

- **Amount of Sexual Assault**
- **Bystander Interventions**
- **Coat of Arms**
- **Females: A Double Bind**
- **Interventions**
- **Is It Sexual Harassment**
- **Making Decisions**
- **Personal Values**
- **Practicing Refusal Skills**
- **Risk Taking**
- **Sexual Assault Impact**
- **Stereotype Adjectives**
- **Victims Map**
- **You Could Be a Sex Offender If...**

Experiential Exercises were developed by Barbara Schwartz and adapted for use as part of the STARRSA program by Lopez, Lamade, & Righthand.

The CERTS Model of Healthy Sex

Consent ✧ means you can freely and comfortably choose whether or not to engage in sexual activity. You are able to stop the activity at any time during the sexual contact.

Equality ✧ means your sense of personal power is on an equal level with your partner. Neither of you dominates the other.

Respect ✧ means you have positive regard for yourself and for your partner. You feel respected by your partner.

Trust ✧ means you trust your partner on both a physical and emotional level. You have mutual acceptance of vulnerability and an ability to respond to it with sensitivity.

Safety ✧ means you feel secure and safe within the sexual setting. You are comfortable with and assertive about where, when and how the sexual activity takes place. You feel safe from the possibility of harm, such as unwanted pregnancy, sexually transmitted infection, and physical injury.

The CERTS model was developed by Wendy Maltz LCSW, DST of www.HealthySex.com and is used here with her permission.

MY PLAN FOR SUCCESS

My plan for success involves making good choices in my life for myself and others. Such choices include not only taking care of me, but relating and engaging with others in respectful and mutually rewarding ways. Strategies to help me make positive choices and live a healthy life are important and involve the following areas. My action plans are described below. (Additional paper may be needed)

1. **Be true to my values:** My values include the following... My strategies for staying true to them include...

2. **Friendships:** Ideas for developing and maintaining positive friendships with people that treat others with respect and dignity include the following...

3. **Trusted confidents and mentors:** Close friends and people I can turn to and count on if needed include... My plans to develop such or additional relationships are...

4. **Sexual feelings, urges and behaviors:** The following outlines how I can express and manage sexual feelings and urges appropriately and satisfy sexual urges in healthy and positive ways.

5. **Ensuring consent:** I will ensure safe, consenting relationships and behavior by taking the following steps to confirm my partner is freely and truly agreeing to engage in sexual relations.

6. **Risk management:** The following outlines risky thoughts, feelings, and situations that can contribute to sexual misconduct and how I can manage them positively and effectively, e.g., describe strategies for positive coping, problems solving and decision-making; avoiding certain peers or situations...

7. **Fun:** I will make time for fun that includes healthy recreational activities and safe socialization, such as... Family: The family members I can count on include... My plans to nurture those relationships and be there for them, as well as develop additional positive family relations include...

8. **Community engagement and making a difference:** I plan to contribute to my community by encouraging others to recognize the problem of sexual misconduct and engage in responsible and respectful behaviors. My strategies may include...

9. **Other ideas:** (tailored to you and your life, e.g., if substance abuse, stress or emotion management are problems, outline plans to address each or any other concern).

DEAR SON LETTER

SON, IT'S OKAY IF YOU DON'T GET LAID TONIGHT

Hey kid. You're at an age where I'm pretty sure you're about to have sex soon, or actually, you might even already be having it and you're just *that* good at keeping it from me. I don't really fret over that because I trust you. And because I trust myself and the job I've done as your parent all these years. Talking or joking about sex was never an uncomfortable, taboo topic in our house, and we've talked about protection, about your responsibility for it, about teen pregnancy, about abortion, about sexually transmitted diseases, about the role masturbation plays in keeping one from entering less-than-ideal relationships. We've talked about the girls you like, and I've always made sure to ask what it is about her personality that does it for you (is she smart? is she hilarious? confident? do you read the same kind of books or does she have different tastes? is she a gamer, too?) and her looks have never been the thing we focus on.

We've also talked about rape and about rape culture. I've tried to show you how this pervasive attitude exists toward women as objects, or at best, supporting characters in a man's adventure. And that even though that isn't your fault and you didn't make the world that way, allowing yourself to be a passive beneficiary of that dynamic is unacceptable. That you must be one of the many people to challenge that, to keep pushing on the outer membrane of this limited paradigm we live in until you've either moved us all somewhere else or you've broken through it. You must trust that if you are doing so in your little area, someone else is doing it in theirs, and another in theirs, and so on. Other mothers and fathers are teaching this to their sons and daughters somewhere.

And yet, the reality is that even with everything I've taught you, you are still capable of committing rape. Not because you're some kind of testosterone-driven monster on the inside, but because you're at the center of swirling variables and messages.

You are friends with boys whose parents may or may not have taught their sons to respect women in the way you've learned. If those guys don't respect women, I want you to be their thought leader. Show them a better way. Don't laugh when they make a disrespectful joke or cat call. Lead by example. If you witness one of them objectifying a woman, make it clear (especially in front of that woman, if you can) that you think it's utter bullshit. Females need to see that, even if it's only a little at a time, guys are evolving.

You receive messaging that suggests the guys you want to emulate are the ones who are getting laid. But the pressure to be "that guy" is what leads to so many bad judgment calls, judgment calls that end up with a girl raped or otherwise violated. Daisy Coleman in Missouri was lured, along with her friend, to a school mate's basement, loaded up with alcohol, raped, and then dumped unconscious to freeze to death in her yard. So was her friend. They were 13 and 14. That's just slightly older than your little sister.

I'd like to get inside the minds of those boys in that basement. They were hanging out together, probably for the umpteenth time, bored, and thought, "there are no girls here, this sucks." It DOES suck when there are no girls around and it's a total sausage fest. NOT because then there's no one to use for release of physiological needs, but because women can be awesome and funny and smart and bring something to a party or situation that is missing if it's only dudes. Women are valuable people for reasons other than owning boobs and a vagina. But that wasn't what those boys had in mind. They actually called this girl and planned to get her so messed up that they could use her as entertainment. And not one of the boys there had the courage to push back against whatever fucked up thing in their head made them interested in this (maybe because they wanted to see if real sex measured up to what they see in porn?). They didn't have the courage to push back against that in themselves, and they certainly didn't have the courage to make their friends stop.

I'd like to think that would never, could never be you. I think better of you and better of your friends to think it would. But the reality is that all human beings are susceptible to momentary lapses of character and judgment, and in groups, it's even more likely. More than anything, I want you to internalize this truth: it's okay if you don't get laid tonight. Or tomorrow night. It's okay if you DO get laid and it's with a girl who truly enjoyed herself, too, but then it's okay if she doesn't sleep with you again. It's okay if it's another year or more before you have sex with anyone again. It's okay, it's okay, it's okay. What's way more important than getting laid is pretty much everything. But specifically, you have core values that will always trump getting laid. Like protecting people. Like looking at every situation and determining what your best role is in it. Like rooting for the underdog and not siding with the people who have power in a given scenario.

Those parts of you are why I think you will always be better than any pressure you experience to "get laid." But because not enough kids get a roadmap, I'm going to give you one.

Here's how you can rule out sleeping with someone:

1. She's hammered.
2. She seems unsure if she wants to (you should never have to talk anyone into it).
3. She's passed out.
4. It seems like there's any other reason she might regret it in the morning. (Even if it's not rape, do you really want to be someone's morning-after regret, when instead they can remember you as a total gentleman?)

Here's how you can be sure it's okay to proceed with sex:

1. She is in control of her faculties.
2. She is enthusiastically willing.

3. Check in with her! “Do you want to be doing this?” is a great thing to ask when things are going to another sexual level. The worst thing that will happen is she'll rethink it and say, no, she's actually not ready. It's important at that point to pivot to doing something else together, and not make her feel guilty for changing her mind. While that may feel like a bummer to you in the moment, what you've just achieved there is fucking badass. You've just put someone else's feelings ahead of your physiological desires. You've just treated somebody the way you hope another guy would treat your sister.

All of this is to say, I actually think you've got this. You're going to do great things in the world as you fully inhabit your manhood, and I think the integrity you're made of is going to come through in all kinds of situations. I really wish you a great, fulfilling sex life where you each mutually benefit and you each come away from it feeling fortified and better for it; not damaged, confused, or disappointed in yourself.

So, if I really think you've got this and I really trust you, why did I write this? I wrote all of this out for you because that's my job. To give you a chance in hell at navigating your way through this crazy, messed up world we live in and maybe even have a little fun while you're doing it. Sexual power is one of the kinds of power. With great power, comes great responsibility. On the flip side, with no power comes no responsibility (h/t Kickass). And that's why it's totally okay if you don't get laid tonight.

Love and hugs and rainbows and all that,

Mom

HOW 7 THINGS THAT HAVE NOTHING TO DO WITH RAPE PERFECTLY ILLUSTRATE THE CONCEPT OF CONSENT

Link: *https://www.upworthy.com/how-7-things-that-have-nothing-to-do-with-rape-perfectly-illustrate-the-concept-of-consent*

SEX AND THE LAW: CAMPUS SEXUAL MISCONDUCT SUPPLEMENTAL HANDOUT

SUGGESTED FOR MODULE 2, SESSION 3

Federal and State Law Applicable to Campus Sexual Misconduct

Campus sexual misconduct is regulated by various Federal and State laws. This document provides a sampling of those laws to further inform students engaged in ongoing intervention methods about laws pertaining to their past and future behavior on campus.

Relevant Federal Law:

- Criminal Law: Although too numerous to list in this handout, there are various Federal laws pertaining to sexual misconduct, including offenses involving sexual acts, sexual contact, and offenses against minors. For additional detail, visit www.smart.gov/sorna.htm.

- Title IX: "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance." 20 U.S.C. § 1681, et. seq.

- Requires institutions to:
  - Proactively ensure their campuses are free of sex-based discrimination, including sexual harassment and other forms of sexual violence.
  - Respond to complaints of sex discrimination, sexual harassment, and sexual violence in a prompt and equitable manner.

- The Clery Act: named after Jeanne Clery, a 19-year-old Lehigh University student who was raped and murdered in her campus residence hall. 20 U.S.C. § 1092(f)

Author: WIlgus

- Requires colleges and universities to:
  - Collect, classify, and count specific crimes occurring on or around their campuses, including: rape, fondling, incest, statutory rape, dating violence, domestic violence, and stalking;
  - Issue campus alerts when there is an ongoing threat or significant emergency that could impact the health or safety of the campus community;
  - Provide educational programs and campaigns to promote awareness of dating violence, domestic violence, sexual assault, and stalking;
  - Have procedures for institutional disciplinary action in cases of dating violence, domestic violence, sexual assault, and stalking;
  - Publish an annual security report; and
  - Submit crime statistics to the U.S. Department of Education

State Laws:

Although students could be charged with a Federal offense if their behavior, for example, occurs on Federal property or impacts interstate commerce, such as soliciting a potential victim via the Internet, students who engage in sexual misconduct are most often charged with violating the criminal laws of their State of residence.

Students are strongly encouraged to identify and review applicable laws in their home State, as well as where they attend school, and review these findings with their therapist.

POWERPOINTS

Sex & the Law

Principle Contributors: Wilgus, Prentky, Righthand and Lamade

Sex and the Law:
Campus Sexual Misconduct

Recommended for Module 2

STARRSA Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- Definition of sexual misconduct
- Consent: What it is & what it is not
- Laws and policies applicable to student sexual misconduct
  - Criminal and civil procedures
  - State Laws
  - Federal Laws
  - Institutional policies
- Possible consequences for violating applicable laws or policies

SEXUAL MISCONDUCT

WHAT IS SEXUAL MISCONDUCT?

- General categories of sexual misconduct are described in the following slides
- Definitions are from the U.S. Department of Education's publication: The Handbook for Campus Safety and Security Reporting (2016 Edition) https://www2.ed.gov/admins/lead/safety/handbook.pdf
- Specific state or federal sexual offenses are not described
- Knowledge of relevant State and Federal laws and institution policies is strongly advised

SEXUAL MISCONDUCT V. RAPE

- In our treatment programs with college students, we consistently use the term "sexual misconduct"
- For the PowerPoint Presentation on "the Law," we use the term applied in legal contexts – "rape"

STATUTORY RAPE

"Sexual intercourse with a person who is under the statutory age of consent."- Department of Justice, 2014

- Example: A 20-year-old student has consensual sex with a 15-year-old juvenile in the older student's on campus apartment. There is no use of force or threat of force, but the statutory age of consent in the State is 16.
- Example: A 19-year-old student has consensual sex with a 17-year-old juvenile in the younger student's dorm room. There is no use of force or threat of force, but the statutory age of consent in the State is 18. *Age of Consent is discussed in further detail later.

FONDLING

Touching of the private body parts of another person for the purpose of sexual gratification, without the consent of the victim, including instances where the victim is incapable of giving consent because of his/her age or because of his/her temporary or permanent mental incapacity.

- Example: A male student reported that another male student touched his genital area in a campus building while telling him that he was glad they could finally be alone. He was offended by the unwanted contact.
- Example: A female student reported a male student put his hand down her shirt and bra at a campus party while saying: "You dress hot, you want this!"

INCEST

Sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law.

- Example: A female student reported she has been feeling uncomfortable because, on three occasions, she had sex with her half-brother in his fraternity house.

SEXUAL HARASSMENT

Unwelcome conduct of a sexual nature, including unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature.

- Example: One of the men touched one of the women's hair commenting about how good it felt and that he'd bet the rest of her feels good too. The woman told him to stop, and the other man said, "Aw, you know you have the hots for him."

See, Dear Colleague Letter. (2011, April 4). Office for Civil Rights, U.S. Department of Education, p.3. https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf

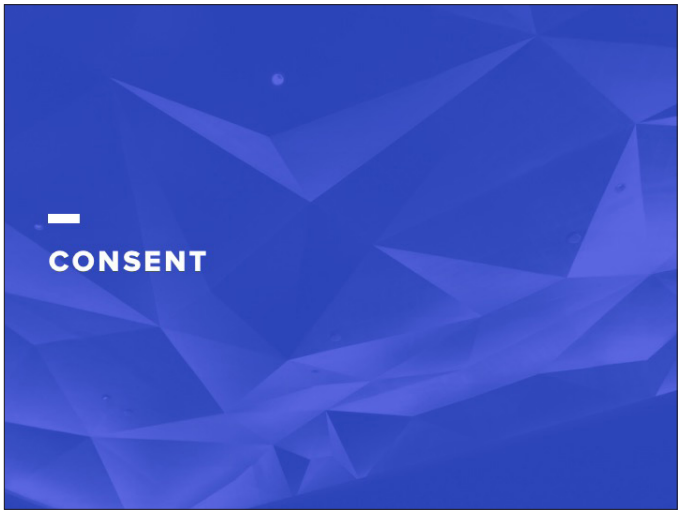
SEXUAL HARASSMENT

- Sending (someone) sexually explicit photographs or messages via mobile phone when those messages are unwelcome or unwanted.
  - Example: A student who identifies as gender-queer reports that a female student, who they saw the previous day in the LGBTQ resource center, sent them a nude selfie that said "Wanna get to know me?"
  - Note: Sexting may also violate state and/or federal law if it includes an image of a person under 18 years old or if sent between minors.

See, Dear Colleague Letter. (2011, April 4). Office for Civil Rights, U.S. Department of Education, p.3. https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf

DEFINING CONSENT

- Consent is a required element for all sexual behavior. Although defined differently at the Federal, State, and Institutional levels, generally speaking, consent is:
  1. Clear and unambiguous agreement,
  2. Voluntarily given,
  3. To engage in a particular activity, and
  4. Expressed outwardly through mutually understandable words or actions.



UNDERSTANDING CONSENT

- Consent to engage in sexual activities:
  - Cannot be obtained through pressure, coercion, or force.
  - Cannot be given by someone who is incapacitated.
  - Cannot be inferred from silence, passivity, lack of resistance, or a previous or existing sexual relationship.
- Consent to engage in sexual activity at one time does not translate into future consent to the same or different activity.

UNDERSTANDING CONSENT

- Consent to engage in sexual activity with one person does not signify consent to engage in similar activity with another person.
- Consent may be withdrawn at any time. Once consent is clearly withdrawn, (e.g., the person says no, don't, I don't want to, or pulls or pushes away), the sexual activity must immediately stop.

COERCION AND FORCE

- Coercion is conduct that utilizes expressed or implied pressure, threats, manipulation, or intimidation to compel another to engage in sexual activity. It may be directed at an individual's physical, emotional, spiritual, reputational, or financial well-being.
  - Example: When his new girlfriend declines his sexual advances, the student remarks: "Come on, you were fine with it last night. You're just a tease. "
  - Example: Thinking her date is losing interest in her, a female student suggests they have sex. When he declines, she tells him: "If you don't have sex with me, I'll tell everyone you're gay."
- Force is the use of physical violence or other physical acts to facilitate sexual activity with another person against that person's wishes.

INCAPACITATION

- "Incapacitation" means that a person lacks the ability to make informed, rational judgments about whether or not to engage in sexual activity.
- A person can be incapable of making informed, rational judgments for any of the following reasons:
  - Voluntary or involuntary consumption of alcohol or drugs,
  - A temporary or permanent mental health condition,
  - Unconsciousness, including individuals who are asleep or "blacked out,"
  - Involuntary physical restraint (e.g., held down), or
  - Being under the age of consent, as described on the following slide.

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- Force is the use of physical violence or other physical acts to facilitate sexual activity with another person against that person's wishes.

AGE OF CONSENT

- Most States require individuals to be a specific age before they can voluntarily consent to sexual activity.
- As explained by the U.S. Department of Education, "[t]he statutory age of consent differs by State and can get complicated. For example, in Maryland, the statutory age of consent is 16 years of age (which means the victim must be under 16); however, 14 and 15-year-olds may consent if the other person is less than four years older than the victim. In Nevada, the age of consent is 16; however, sexual intercourse with someone who is under 16 years of age is illegal only if the defendant is at least 18 years of age (the age at which the defendant can be prosecuted)."
- Students are strongly encouraged to consult their state's statutes to determine the statutory age of consent where they live or attend school.

See, Dear Colleague Letter. (2011, April 4). Office for Civil Rights, U.S. Department of Education, p.3. https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf

BURDEN OF KNOWLEDGE

- Although not expressly stated in some laws or policies, it is generally true that the burden of knowing whether or not consent exists rests with the person initiating or seeking sexual contact.
- For example, the University of Michigan asks "whether the Respondent knew, or reasonably should have known, that the activity in question was not consensual, or that the Claimant was unable to consent due to incapacitation." More specifically, the University of Michigan asks:
  - "Did the person initiating sexual activity know that the other party was incapacitated? and, if not, (2) Should a sober, reasonable person, in the same situation, have known that the other party was incapacitated? If the answer to either of these questions is 'yes,' consent was absent and the conduct is likely a violation of this Policy."

See, University of Michigan Policy and Procedures on Student Sexual and Gender-Based Misconduct and Other Forms of Interpersonal Violence, p. 14-15. https://studentsexualmisconductpolicy.umich.edu/files/smp/SSMP-FINAL-062916.pdf

LAWS & POLICIES

LAWS AND POLICIES APPLICABLE TO STUDENT SEXUAL MISCONDUCT

- Sexual misconduct is a serious offense that often impacts multiple people and communities. As such, students who engage in sexual misconduct can be held accountable criminally, civilly, and/or institutionally for their behavior.
- Each process operates independently and may proceed simultaneously or at different times for the same underlying behavior. This is not "double jeopardy." This reflects the fact that sexual misconduct can violate multiple laws and policies at the same time.
  - The following slides briefly explain:
  - Criminal and civil procedures as they relate to student sexual misconduct;
  - State and federal law applicable to student sexual misconduct;
  - Institutional policies applicable to student sexual misconduct; and
  - Consequences for violating applicable law or institutional policy.

CRIMINAL VS. CIVIL PROCEDURES

- Criminal Procedures: Students who engage in sexual misconduct can be charged with violating criminal law by State or Federal prosecutors. If a student is ultimately found guilty of that crime, penalties can include jail time, lifetime registration and monitoring as a sex-offender, limitations on future employment, and more.
- Civil Procedures: Students who engage in sexual misconduct can also be sued directly by their victim or other harmed parties in civil court. If determined to be responsible for the harm, students can, among other things, be forced to pay a monetary penalty or restitution.
  - Example: After being physically confined and raped by a former friend in a dorm room, a female student reports the incident to the university, files a report with the police, and initiates a lawsuit against the perpetrator for battery, false imprisonment, and intentional infliction of emotional distress.

STATE AND FEDERAL LAW

- Although State law is most often applicable to student sexual misconduct, it's also possible for students to violate Federal law in the course of their actions.
  - For example, if the behavior occurs at a military college or if the conduct involves activities that cross state lines, such as using the internet to access pornography involving underage juveniles, a student could be charged with a Federal crime.
- Additional information about State and Federal laws applicable to student sexual misconduct can be found in the Supplemental Handout for this training session.
- Because laws vary so significantly by State, students are strongly encouraged to familiarize themselves with relevant law in the State where they live or attend school.

EXAMPLE: CHILD PORNOGRAPHY

- It is a violation of federal law and most state law to produce, distribute, receive, or possess any visual depiction of sexually explicit conduct involving a minor (someone under 18 years of age).
- Visual depictions include photographs, videos, digital, or computer generated images indistinguishable from an actual minor, and images created, adapted, or modified, but appear to depict an identifiable, actual minor.
- Undeveloped film, undeveloped videotape, and electronically stored data that can be converted into a visual image of child pornography are also deemed illegal visual depictions under federal law.
- The legal definition of sexually explicit conduct does not require that an image depict a child engaging in sexual activity. A picture of a naked child may constitute illegal child pornography if it is sufficiently sexually suggestive.

See, www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-child-pornography

- Additionally, the age of consent for sexual activity in a given state is irrelevant. Any depiction of a minor under 18 years of age engaging in sexually explicit conduct is illegal.
- It is also illegal to persuade, induce, entice, or coerce a minor to engage in sexually explicit conduct for purposes of producing visual depictions of that conduct.
- Federal jurisdiction is implicated if the child pornography offense occurred in interstate or foreign commerce. This includes, for example, using the U.S. Mails or common carriers to transport child pornography across state or international borders. Additionally, federal jurisdiction almost always applies when the Internet is used to commit a child pornography violation. Even if the child pornography image itself did not travel across state or international borders, federal law may be implicated if the materials, such as the computer used to download the image, originated or previously traveled in interstate or foreign commerce.

For additional information about the law surrounding child pornography, see: www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-child-pornography

INSTITUTIONAL POLICIES

- In addition to Federal and State law, students are responsible for complying with specific policies adopted and published by their college or university.
- These policies, which are often called a "Student Code of Conduct" or something similar, describe:
  - Behavior that is prohibited at the institution,
  - Methods for reporting prohibited behavior,
  - Procedures to be used in addressing reported behavior, and
  - Consequences for violating institutional policy.
- Each student should be familiar with their institution's Student Code of Conduct.

CONSEQUENCES

CONSEQUENCES FOR VIOLATING INSTITUTIONAL POLICY

- No matter which college or university a student attends, the consequences for violating institutional policy related to sexual misconduct are similar.
- Students found responsible for sexual misconduct are subject to a range of sanctions including: disciplinary probation; restitution; restriction from employment at the institution; removal from specific courses or activities; mandatory completion of an educational workshop, training, project or treatment; or an order to refrain from contact with certain individuals, including the victim.
- Consequences may also include suspension, expulsion, transcript notation, notification to other institutions, or even the withholding or revocation of a degree.

OTHER CONSEQUENCES:

- In addition to the criminal, civil, or institutional consequences discussed previously, individuals who engage in sexual misconduct may experience other consequences from their behavior, including, but not limited to:
  - Reputational harm
  - Social ostracization
  - Family problems
  - Mental health difficulties
  - Trouble finding employment
  - Difficulty finding housing

CONCLUSION:

- Sexual misconduct is a serious offense that can result from intentional action, or failure to properly understand and respect appropriate boundaries concerning consent.
- Sexual misconduct is regulated at the State, Federal, and institutional levels through a system of laws and policies that are designed to:
  - Maintain peace and productivity in society,
  - Establish standards that create clarity and safety,
  - Cultivate and ensure the existence of adequate order,
  - Provide ways to resolve disputes, and
  - Protect civil liberties and individual rights.
- Students are responsible for familiarizing themselves with applicable law and policies and behaving accordingly. Failure to do so can result in serious consequences.

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Supplemental Slides: Dating Violence, Domestic Violence, and Stalking

The slides that follow regarding Dating Violence, Domestic Violence, and Stalking may be moved forward and weaved into the primary session if deemed appropriate by the treating clinician based on what they know of the student and/or the underlying behavior at issue.

Definitions are from the U.S. Department of Education's publication: The Handbook for Campus Safety and Security Reporting (2016 Edition)https://www2.ed.gov/admins/lead/safety/handbook.pdf

DATING VIOLENCE

- Violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim. The existence of such a relationship shall be determined based on the reporting party's statement and with consideration of the length of the relationship, the type of relationship, and the frequency of interaction between the persons involved in the relationship.
  - Example: A female student cuts her ex-boyfriend with a knife during an altercation in an on-campus dining hall.

DOMESTIC VIOLENCE

- A felony or misdemeanor crime of violence committed:
  - By a current or former spouse or intimate partner of the victim,
  - By a person with whom the victim shares a child,
  - By a person who is cohabitating with, or has cohabitated with the victim as a spouse or intimate partner,
  - By a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred,
  - By any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction in which the crime of violence occurred.
  - **Example**: A neighbor reports yelling in the apartment next door in a university housing complex. A police officer arrives and finds a husband and wife having an argument. The wife has visible physical injuries on her face and arms.

STALKING

- Engaging in a course of conduct directed at a specific person that would cause a reasonable person to:
  - Fear for the person's safety or the safety of others; or
  - Suffer substantial emotional distress.
- For the purposes of this definition:
  - Course of conduct means two or more acts, including, but not limited to, acts in which the stalker directly, indirectly, or through third parties, by any action, method, device, or means, follows, monitors, observes, surveils, threatens, or communicates to or about a person, or interferes with a person's property.
  - Reasonable person means a reasonable person under similar circumstances and with similar identities to the victim.
  - Substantial emotional distress means significant mental suffering or anguish that may, but does not necessarily require medical or other professional treatment or counseling.

STALKING

- Example: A female student reported that she is afraid for her safety because her ex-boyfriend has been sending harassing emails over the past several weeks. She told him she didn't want to talk to him any more, but the emails have persisted.

POWERPOINTS

Changing Times

Principle Contributors: Prentky, Righthand, Lamade, & Lopez

Changing Times

Recommended for Module 8

STARRSA | Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- What do we mean by "changing times" and why talk about it?
- A look at the change in pop-culture over the years.
- Women's accomplishments in:
  - athletics
  - military
  - politics
  - corporate / wealth management

Let's start with another idea that we explored in a PP on "Herding"

- Millions of years of evolution have left us with a hard-wired, built-in attraction to what is "familiar." Prehistoric hunter-gatherers (say 10,000 – 15,000 years ago) lived in small "clans" and had much to fear from other roving clans that they didn't recognize (were unfamiliar). They were potential threats.
- What feels instinctively "safe" is that which evokes greatest similarity to ourselves. What is instinctively unsafe is often feared. This instinctive emotional response can fuel race, ethnic, & religious prejudice and even hatred.

We are no longer small clans or tribes but large Nation States

- that are highly diverse and heterogeneous
- Other than living in the same Nation State, we often look different, speak different tongues, practice different religions, have different values, customs, and practices
- Familiarity is no longer easily preserved; we no longer automatically see a fellow American as "familiar" and thus "like us" and thus trustworthy
- The American may be dark-skinned, speak with a strong accent, wear a hijab

- We are no longer strictly a White Anglo-Saxon, Protestant nation; within a few decades (around 2045), Caucasians will be a numeric minority in the U.S.
- reflecting varying degrees of unfamiliarity and thus varying degrees of unease, ranging from mild discomfort to abject fear
- The response to fear can be highly toxic, including extraordinary measures (e.g., violence) to demand a restoration of familiarity (e.g., closing the "gates" to keep out "foreigners," especially those that are unfamiliar; expelling certain groups of immigrants)
- Often our responses are so extreme they are high jacked by our fear
- When women wear "scarves" (hijab), we automatically identify them as Muslim and thus "different," yet

Catholic nuns may wear very similar head covering.

Even the full body covering is very similar to the burqa.

- By now, Catholics are fully assimilated in the U.S. and are no longer “unfamiliar.”
- After all, almost 60 years ago one was elected President (overcoming fear that, if elected, the Vatican would run the White House)
- But “push-back” against “change” is still very much alive; it just metamorphoses into different perceived threats from the unfamiliar

August 5, 2012 Wade Michael Page, a white supremacist, killed 6 people & wounded 4 others in a Sikh Temple, confusing Sikhs with Muslims

There is a Middle High German (Yiddish) expression called “landsman”

- landsman captures this universal sense of familiarity. During the Middle Ages, when traveling to distant unknown lands and fearing reception from the locals, Jews felt instant relief when meeting a fellow Jew, a “landsman,” *thinking he/she could be trusted.* In a truly dangerous world, this knowledge could translate into survival.
- Whether the fellow traveler could objectively be trusted merely because of religious affiliation is questionable of course

- The relevance is the universality of this *gut feeling* that someone can be trusted because of their *familiarity or similarity* (whether it is based on race, ethnicity, nationality, religious affiliation, or other characteristics.
- Those who were accused of witchcraft in Salem, for instance, were dissimilar, because they were social outcasts by virtue of their breeding, class status, skin color, or their origin. They were all “different” from the Colonists in Massachusetts in the late 17th Century. The Puritans were White, British, and deeply religious, though intent on reforming the Church of England.
- The point of raising this discussion of familiarity is to pose a yet unmentioned but profound expression of dis-similarity: **Gender**

Let’s take a quick look at what appear to be shrinking differences between men and women when women are allowed to compete on an equal playing field…

and what it may mean

POP CULTURE

… are our icons changing?

Let's take a quick look at the shrinking differences between men and women when women are allowed to compete on an equal playing field.

KATNISS EVERDEEN






- One unwitting, unintended icon is the post-apocalyptic heroine of Hunger Games: Katniss
- There is something unique about the portrayal of Katniss Everdeen, the character from Suzanne Collins's trilogy.
- She clearly is a heroine, but unlike most depictions of heroines, she is **not** a sex symbol, attractive yes, but her femininity is **not** what defines her.

- She has the internal **strength, fortitude, courage, stamina** that you might expect of fictional male heroes - Stallone, Eastwood, Connery, Willis, Schwarzenegger, Lee, The Rock, etc.
- **She fights her own battles** - a trait associated with every male hero; she does not rely on men
- She kisses the boys – but evidences no clinging dependence on them; if anything, she rescues them rather than the reverse

IMPERATOR FURIOSA



- Mad Max: Fury Road Charlize Theron is the savior of the many "wives" of Mad Max (Assisted by a band of gray-haired, motorcycle matriarchs)
- Again, that is characteristically the role of the man **"to rescue the (helpless) fair maiden in distress"**

Before moving on, take a quick look at the far left picture of "Imperator Furiosa" (Theron)

WONDERWOMAN - 2017

ACTRESS GAL GADOT WHO PLAYED DIANA (WONDER WOMAN):

“I think as a feminist, you should be able to wear whatever you like. Feminism is about equality and choice and freedom. And the writers, Patty and myself all figured that the best way to show that is to show Diana as having no awareness of social roles. **She has no gender boundaries. To her, everyone is equal.**”

"Wonder Woman can be charming and warm — **she just happens to be a demigoddess who can beat the shit out of you**," says Gal Gadot.

“We love how fresh and timely it feels to be coming out with **a kick-ass female superhero** movie right now, **giving a lesson in some serious female empowerment**," says Toby Emmerich, president at Warners.

SPORTS

- In 1978, a now classic image appeared on the cover of Time Magazine, the photo of a young female lacrosse player, her face expressing the typical ***“higher-primate threat”*** - common to the innate wiring observed in all monkeys, apes, and humans **- often noted in men but rarely ever seen (at least publically) in women.**
- We are seeing that “higher-primate response” more and more frequently in women athletes.

- Do you recall now, Theron's face in **Mad Max**?

TITLE IX: IMMEDIATE IMPACT OF SPORTS / ATHLETICS IN HIGH SCHOOL & COLLEGE

- Title IX is a federal civil rights law in the United States of America that was passed as part of the Education Amendments of 1972
- **"No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any education program or activity receiving Federal financial assistance." –Title IX, Education Amendments of 1972**

By 2014, the number of women in high school sports increased 11x and the number in college sports 12x.

- The **1999** World Cup Women's Soccer final in California had an attendance of **90,185**, a world record for a women's sporting event.
- Women's World Cup, Canada, 2015 earned TV ratings **3 times higher** than the Stanley Cup Final.
- An average audience of **25.4** million in the U.S. watched the final match with Japan on FOX, **the highest viewing for any football match broadcast on U.S. television.**
- These figures exceeded the previous high set during the USA-Portugal **men's** match in 2014 and **exceeded the viewing figures for every game from the NBA Finals**.

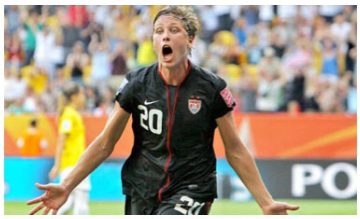
MIA HAMM

- "True champions aren't always the ones that win, **but those with the most guts**,"
- Once again, look at the images caught of her face

MIA HAMM'S COMMENTS

- "True champions aren't always the ones that win, **but those with the most guts**,"
- This sounds more like Sylvester Stallone in Rocky than coming from a women.
- Keep in mind, Rocky was a fictional character and anything that Stallone said was written by a script writer.
- Mia Hamm is **not** a fictional character; what she said comes from somewhere deep inside of her; **it's who she is**; it's where she "lives."

AMY WAMBACH



Once again, look at the images caught of her face

Higher primate, teeth barred, typical of men when they are pushed to the limit; we now see it more and more in women when pushed to the limit; with the demand for 1 last once of stamina and perseverance.

- 2008, Wambach lifted on to a stretcher after injuring her leg when she collided with a Brazilian player
- 2015, collision with Ireland goalkeeper, Wambach **broke her nose but remained in the game** – a reporter said: "Her resolve unbreakable, Her nose? Well..."

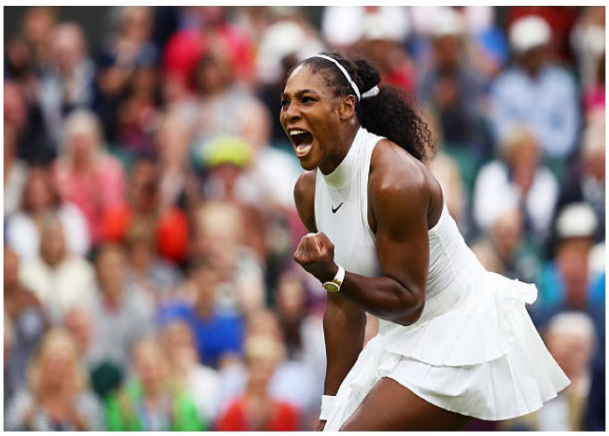
- Broken nose? Screw it; I'm not leaving the game.
- Sounds again a bit like Rocky. Eyes swollen shut. Blind? Screw it. Slit them open. I'm going back into the ring. Remember the scene? Who could forget it.
- Again, Rocky is fictional. He never had his swollen eye slit open; he never had a broken nose. In real life, as an actor, he probably would have left the ring!
- **Wombach is not fiction. Her nose was broken, and she went back onto the field anyway. "Her resolve unbreakable..."**

VENUS & SERENA WILLIAMS

- There are not just elite athletes and "superstars," "The Williams sisters changed tennis forever, by demanding equal pay with male tennis stars, and by forcing their competitors to step it up, Women's tennis is faster, more powerful and more exciting..." (McCann, 2018).
- Between the two of them, they have won 12 Wimbledon titles; Venus has won 7 Grand Slams and Serena has won 23 Grand Slams; they have each won 4 Gold Medals at 3 different Olympics..

SERENA WILLIAMS: WIMBLEDON DAY 12

Again, the facial expression.



- Perhaps most remarkable – and little known: Serena won the Australian Open on January 28, at age 35 and **2-months pregnant**. She defeated her sister Venus, and did not drop 1 set in the entire match (6-4; 6-4).

THIS NEWS WENT VIRAL

- "The news that Serena Williams won the Australian Open final while eight weeks pregnant has sent the world into a frenzy. Some evidently still think that women are the fairer sex, the weaker and the less capable of the two genders. Believe me when I say we are far from fragile," N. Henry, 4-20-17, The Guardian
- Is Serena the only female super-athlete to win world championships when pregnant?

ONE OF AMERICA'S TOP FEMALE TRACK STARS: ALYSIA MONTANO

- SACRAMENTO — "Alysia Montano took two laps at nationals while pregnant with her first child. It was only fair she do the same with baby No 2.
- Five months pregnant, the 800-meter runner finished more than 19 seconds behind the winning time Thursday night at the U.S. track and field championships in extreme heat.
- She never felt better.
- "Amazing," said Montano, who chased her nearly 3-year-old daughter around after the race.

- Wearing a customized Wonder Woman top and the trademark flower in her hair, Montano finished in 2 minutes, 21.40 seconds to eclipse her previous-best pregnancy time by nearly 11 seconds. Of course, she was eight months pregnant when she attempted the endeavor in 2014 at the same track," AP, June 23, 2017.

- Alysia preparing for the 800-meter heat at the June, 2017 U.S. Outdoor Championships: 5 months pregnant, in 110 heat

Rock Climbing / Mountain Climbing: long considered an impenetrable male dominated sport

SASHA DIGIULIAN

- Sasha Digiulian's bid to join the most exclusive (all-male) club in outdoor rock climbing
- Sasha DiGiulian is the **first woman and the first American** to climb Magic Mushroom on the Eiger

THE INFAMOUS NORTH FACE OF THE EIGER

- There is no route up Switzerland's 13,000 foot Eiger that is easy; one route – the 23-pitch, 3,000 foot La Paciencia, is widely viewed as one of the hardest pure rock climbs in the entire Swiss Alps.
- Only about 5 men in the world have climbed it and **at least 64 men have died trying**.

JON KRAKAUER – EIGER DREAMS

- "The problem with climbing the North Face of the Eiger is that in addition to getting up 6,000 vertical feet of crumbling limestone and black ice, one must climb over some formidable mythology. The trickiest moves on any climb are the mental ones, the psychological gymnastics that keep terror in check, and the Eiger's grim aura is intimidating enough to rattle anyone's poise."

SASHA DIGIULIAN

- 22 years old was an Undergraduate @ Columbia University
- Three time U.S. Champion in indoor rock climbing
- Current female World Champion
- The Eiger: daunting for any climber – 3 grueling days of 12-18 hours of climbing, long spaces between bolts & highly unpredictable alpine weather

This 22-year-old woman did what 64+ men died trying to do

IS SASHA AN ANOMALY?

- Competitive rock climbing among women is getting to be a crowded field:
- Josune Bereziartu, is a Spanish rock climber; She is recognized as the first woman to climb 8C (5.14b), 8C+ (5.14c), 9a (5.14d) and 9a/9a+ routes. Josune married her climbing partner; his climbing level of 8b+.

IS SASHA AN ANOMALY?

- Charlotte Durif is a French rock climber with many records: 3rd at the World Championship in overall, 2016; World Champion in overall, 2014; World Champion 5 times in lead Youth between 2004 and 2009; European Champion in lead Adults at the age of 15; 16 time French Champion from 2005 to 2015, in all categories and disciplines; she has more than 580 routes 8a and up, 23 routes 8c and up; 8A bouldering
- Shauna Coxsey is a British rock climber who won the International Federation of Sport Climbing World Cup in 2016 and 2017, among her 28 medals in climbing competition

ASHIMA SHIRAISHI

- Among such stiff competition, Ashima Shiraishi is still considered by some "the best climber in the world" and she is 17 years old
- Ashima is a Japanese-American rock climber who is so extraordinary, the media has names for her: "the young crusher" (Outside Magazine), "the Bouldering Phenom" (N.Y. Times), "the legend," "the prodigy."
- Her "notable ascents" and "Redpointed Routes" are far too numerous to mention.
- She is sponsored by The North Face, Cliff Bar, Coca Cola, and Nikon, among others.

ASHIMA SHIRAISHI

- She "is widely considered to be the best teenage climber of either gender" in the world.
- "The climbing world is buzzing as 13-year-old Ashima Shiraishi has begun to conquer some of the world's hardest climbs" 2015 Reel Rock
- "At just 17 years old, Ashima is the best climber in the world. Even more improbable is the fact that she's still (mostly) a normal teenager," Outside Online.

Ashima, again, is not alone. She has so much "competition" among young girls / women her age, there are many videos comparing the climbing style of Ashima with other prominent international rock climbers

- **Ashima vs. Janja Garnbret (Slovenian rock climber)**
- **Ashima vs. Brooke Raboutou (American rock climber)**
- **Ashima vs. Jain Kim (South Korean rock climber)**
- **Ashima vs. Alexandrea (Alex) Puccio (American rock climber)**
- **Ashima vs. Emily Harrington (American rock climber)**

Mt Everest?

ANSHU JAMSENPA, MOUNTAINEER

- Anshu Jamsenpa, set a new record after she climbed mount Everest **twice in less than a week** (2017).
- In 2011, she did her first double assent of Mt. Everest, that time it took 10 days.

She appears to have accomplished exactly what the 29-year-old Catalonian male mountaineer Kilian Jornet did, who reached the summit twice within 5 days.

2016 SUMMER OLYMPICS

- Overall, Americans won 121 medals, but **it was the women that won the majority of them** (this was also true in the London Olympics 4 years ago).
- The women won 61, the men won 55 (and 5 were in mixed events, such as equestrian and mixed-doubles tennis).
- **The women won 27 of the 46 American gold metals (58.7%).**

TO PUT THIS FEAT IN PERSPECTIVE:

- If American male athletes never attended the Olympics, and the U.S. was **only represented by women**:
- American women alone would have tied for 1st place in the world

Country	Gold Medals Won
Great Britian	27
American Women (only)	27
China	26
Russia	19

WAS THIS A "ONE-OFF" PERFORMANCE?

- In the London Summer Olympics, American women won 58 medals (56%) compared with 45 for U.S. men.
- American women are now dominant throughout the world in gymnastics, swimming, basketball, rowing, water polo and soccer.
- 2016 was the first time American women settled for Silver in soccer; they were upset by Sweden.

This is the effect of Title IX and the change brought about by allowing women to compete on a level field:

1972 Olympics in Munich: American women won 23 medals (24%) compared with 71 for the U.S. men . The women didn't win a single medal in gymnastics and had no gold Medals in track and field.

By 2016, there were more women (291) than men (263) on the U.S. Olympic Team

TO BE CLEAR:

- **When women were "allowed" by men to train and compete at the highest level of international athletic competition, it became crystal clear that women could do what men could do.**
- This success cuts two ways, for some men it is threatening.
- In the long term, it will hopefully decrease the most toxic discrimination.

MILITARY

"These 2 badass female Army Rangers just made history"

CAPT. KRISTEN GRIEST & 1ST LT. SHAYE HAVER

- The first female soldiers to graduate from Army Ranger School, August 21, 2015

COMMENTS FROM FELLOW MALE RANGERS

"If I remember correctly, Ranger Griest carried the M240 for her squad on day one of patrols and another female in her squad carried the radio as the RTO. The next day of patrols, they switched, with Ranger Griest humping the radio, and the other female student carrying the M240 … **Physically, they were studs**" Mac added

"I went to school with Shaye [Haver], **and I knew she was a physical stud**. But I was skeptical of whether or not she could handle it because this is my third time at a Ranger School" fellow Ranger candidate 2nd Lt. Michael Janowski

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GENDER COMPLETION OF RANGER SCHOOL

Men: 94 out of 380 – 24.7% passed

Women: 02 out of 18 – 11.0% passed the 1st time

Again, male terminology used to describe women doing what (some) men were able to do.

"physically, they were studs…"

"They were badass Army Rangers"

NORTH KOREAN PEOPLE'S ARMY

"Supreme leader" Kim Jong-un of NK can integrate his army but the U.S. cannot? Reportedly **40% (500,000) of NKPA are women**.

So what's the real issue?

"The Real Barrier for Women Marines" - N.Y. Times, July 18, 2015

- "Physical fitness is not the problem. The corps' culture is"
- "The infantry is the soul of the corps... I experienced how this all-male culture nurtures an intense brotherhood, an alchemical bond... the real reason many Marines don't want women in the infantry is that it will forever change that culture."

POLITICS

Women have been elected prime minister or president of 56 of the 146 nations (38%) in the world according to the World Economic Forum

India, Israel, Ceylon, Sri Lanka, Portugal, United Kingdom, Germany, Yugoslavia, Norway, Central African Republic, France, Lithuania, Pakistan, Bangladesh, Canada, Turkey, Bulgaria, Rwanda, Burundi, Haiti, New Zealand, Guyana, Mongolia, Peru, Finland, South Korea, Senegal, Bahamas, Macedonia, Mozambique, Ukraine, Croatia, Iceland, Australia, Thailand, Mali, Denmark, Jamaica, Latvia, Poland, Moldova, Namibia, Trinidad and Tobago, Argentina, Liberia, Brazil, Kosovo, Chile

Bandaranaike, S.	Sri Lanka	3x – 1960-65, 70-77, 94-2000
Gandhi, Indira	India	2x – 66-77, 80-84
DabCeviC-KuCar, S.	Croatia	67 – 69
Meir, Golda	Israel	69 – 74
Domitien, E.	Central African Republic	75 – 76
Thatcher, Margaret	United Kingdom	79 – 90
De Lourdes Pintasilgo	Portugal	79 - 80
Charles, M. E.	Dominica	80 – 95
Brundtland, Gro	Norway	3x – 81, 86-89, 90-96
Planinc, M.	Yugoslavia	82-86
Bhutto, Benazir	Pakistan	2x – 88-90, 93-96
Prunskiene, k.	Lithuania	90-91
Zia, K.	Bangladesh	2x – 91-96, 01-06
Cresson, E.	France	91 – 92
Suchocka, H.	Poland	92 - 93

Campbell, Kim	Canada	1993
Ciller, T.	Turkey	93 – 96
Kinigi, S.	Burundi	93 - 94
Uwilingiyimana, A.	Rwanda	93 – 94
Kumaratunga, C.	Sri Lanka	94
Indzhova, R.	Bulgaria	94 - 95
Werleigh, C.	Haiti	95 – 96
Wajed, S. H.	Bangladesh	2x – 96 -01, 09
Jagan, J.	Guyana	97
Shipley, Jenny	New Zealand	97 – 99
Degutiene, I.	Lithuania	2x – 99
Tuyaa, N-O.	Mongolia	99
Clark, Helen	New Zealand	99 – 08
Boye, M.	Senegal	01 – 02
Sang, C.	South Korea	02

Baptista de Sousa, M.	Sao Tome and Principe	02 – 03
Jaatteenmaki, A.	Finland	03
Lucero, B. M.	Peru	03
Diogo, L.	Mozambique	04 – 10
Sekerinska, R.	Macedonia	2x - 04
Tymoshenko, Y.	Ukraine	2x – 05, 07 – 10
Carmo Silveira	Sao Tome and Principe	05 – 06
Merkel, Angela	Germany	3x – 2005 - present
Simpson-Miller, P.	Jamaica	2x – 06 – 11, 12
Sook, H. M.	South Korea	06 – 07
Greceanii, Z.	Moldova	08 – 09
Pierre-Louis, M.	Haiti	08 – 09
Sigurdardottir, J.	Iceland	09 – present
Kosor, J.	Croatia	09 – 11
Manorohanta, C.	Madagascar	09

Fernández de Kirchner, C.	Argentina	03 - 07
Martínez de Perón, I.	Argentina	74 - 76
Otunbayeva, R.	Kyrgystan	10
Persad-Bissessar	Trinidad and Tobago	10 – present
Kiviniemi, m.	Finland	10 – 11
Gillard, Julia	Australia	10 – 13
RadiCova, I.	Slovakia	10 – 12
Figueroa, R. F.	Peru	11
Sidibe, C. M. K.	Mali	11 - 12
Shinawatra, Y.	Thailand	11 – present
Thorning-Schmidt, h.	Denmark	11 – present
Nandigna, M. A. D.	Guinea-Bissau	12
Bratusek, A.	Slovenia	13 – present
Solberg, E.	Norway	13 – present
Straujuma, L.	Latvia	14 - present

Anglo Countries	Women Head of Government
Australia	Y
Denmark	Y
Norway	Y
Finland	Y
Iceland	Y
Sweden	Y
New Zealand	Y
Germany	Y
France	Y
United Kingdom	Y
Portugal	Y
Canada	Y
Poland	Y
Israel	Y
United States	N
Italy	N
Austria	N
Spain	N

WEALTH

WEALTH = POWER

historically, wealth has always been held by men

Dramatic gender shift in wealth: from dependence & powerlessness to independence, control & throw-weight

http://she-conomy.com/facts-on-women

WEALTH

Over the next decade, **women will control two thirds of consumer wealth in the United States and be the beneficiaries of the largest transference of wealth in our country's history**. Estimates range from $12 to $40 trillion. Many Boomer women will experience a double inheritance windfall, from both parents and husband. The Boomer woman is a consumer that luxury brands want to resonate with.

– Claire Behar, Senior Partner and Director, New Business Development, Fleishman-Hillard New York

WEALTH

Of the 743 women of wealth interviewed with at least $3 million in investable assets**, 61.2% accumulated their fortunes through corporate employment**, their own or a family business or a professional practice. Only 38.8% of the women had married into or inherited their money.

– Women of Wealth, 2004, by Russ Alan Prince and Hannah Shaw Grove

WEALTH

High-net-worth women account for 39% of the country's top wealth earners; 2.5 million of them have combined assets of $4.2 trillion. More than 1.3 million women professionals and executives earn in excess of $100,000 annually. 43% of Americans with more than $500,000 in assets are female

– MassMutual Financial Group–2007

WEALTH

"The number of wealthy women investors in the U.S. is growing at a faster rate than that of men. In a two-year period, **the number of wealthy women in the U.S. grew 68%,** while the number of men grew only 36%."

– The Spectrem Group

Wealthy boomer women are the marquee players in our country's culture and commerce. They are educated, have a high income, and **make 95 percent of the purchase decisions for their households**.

– Karen Vogel, The Women's Congress and co-founder and president of New Generation Event Solutions

POWER BROKERS

FEMALE POWER BROKERS INVADING THE MALE CITADEL

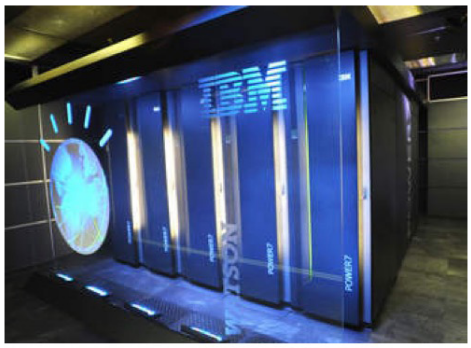
Name 1 individual so brilliant and so creative as to have accomplished the following:

- This individual won Jeopardy by defeating the greatest champion of all time, Ken Jennings, who had won 74 consecutive times on Jeopardy; his winning streak came to an end in 2011.
- This same individual wrote an award-winning cookbook.
- This same individual developed very successful trailers for major motion pictures (and very quickly).
- This same individual memorized 1 million technical medical treatises and developed the highest tech. health care diagnostic system in the world.

CLUE...

It's not an individual

It's IBM's Watson



And who
is in charge?

Change Often Begets Fear, and with it, Resistance

This is the classic Jackie Robinson story: 60 years after J.R. broke the color line in pro baseball, the color line is nonexistent, certainly not in pro football or pro basketball.

Lessons learned thus far,
the mythic ideal of "man"
is simply that – a myth

The mythic ideal exists but it is human; it is not gender-based

We have seen fewer and fewer things that only men excel at, and those few things relate primarily to greater muscle mass

Whatever we regard as the mythic ideal; whatever we pay greatest homage to; whatever we most respect in others; those traits should be gender neutral. Then and only then we will have achieved some degree of gender equality.

When men acknowledge that women possess the same full range of potential skills, strengths, and expertise formally ascribed only to men,

Women will cease to "look" like nothing more than sexual objects.

AND PERHAPS MORE TO THE POINT…

- When men acknowledge that women can possess the same full range of traits that men have always admired as defining features of what it means "to be a man," the courage, the "grit," the perseverance, the tenacity, the daring, the temerity, the bravery, women may cease to look like a different species that belong shuttered in the kitchen.
- The vast majority of men and women possess the traits above only in varying degrees, some men more than others, same with women, in varying degrees, some women more than others.
- When we see these traits, we can prize them in both men and women.

Who sits atop one of the largest technology corporations in the world, with over 100 billion $ in assets?

Virginia (Ginni) Rometty CEO,
President and Chairwoman of IBM
Forbes' 11th most powerful woman in the world.

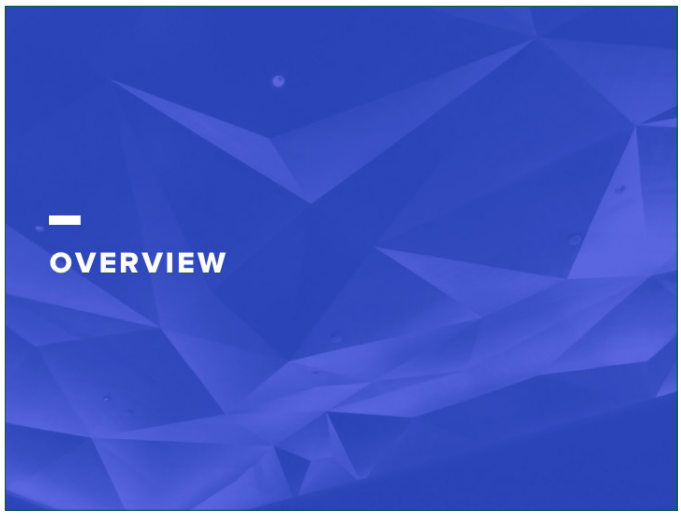
IS ROMETTY "ONE-OFF"?

A few other world leaders in technology:

- **Mary Barra, CEO of General Motors;**
- **Marillyn Hewson, CEO of Lockheed Martin;**
- **Beth Comstock, Vice-Chairman of General Electric;**
- **Phebe Novakovic, CEO of General Dynamics;**
- **Safra Catz, co-CEO of Oracle;**
- **Angela Ahrendts, SVP of Apple;**
- **Meg Whitman, CEO of Hewlett-Packard;**
- **Sheryl Sandberg, COO of Facebook;**
- **Ursula Burns, Chairwoman of VEON; former CEO of Xerox;**
- **Susan Wajcicki, CEO of YouTube.**

WORLD OF FINANCE

- **Janet Yellen, Former Chair of the Federal Reserve Board**
- **Ana Patricia Botin, Chair of the Santander Group**
- **Christine Lagarde, Managing Director of the IMF (International Monetary Fund)**
- **Abigail Johnson, President & CEO of Fidelity Investments**



Widespread publicity of cultural shift to “casual” sex – friendships now have “benefits” – huge change in sexual mores.

Women in ever increasing presence in jobs held exclusively by men – some presence is highly visible, such as airline pilots.

Women breaking into impregnable male fortresses – such as the Army Rangers.

Women pro sports (soccer) now dominating even men’s pro sports in viewership.

POWERPOINTS

Drugs & Sexual Misconduct

Principle Contributors: Prentky, Righthand, Lamade, & Lopez

Drugs & Sexual Misconduct

Recommended for Module 4

STARRSA Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- Alcohol
- Barbiturates
- Cocaine
- Drugs used to facilitate sexual misconduct

ALCOHOL

NATIONAL SURVEY ON DRUG USE AND HEALTH (2015)

- **Prevalence of Drinking:** 58% of full-time college students ages 18–22 drank alcohol in the past month compared with 48% of other persons of the same age.
- **Prevalence of Binge Drinking:** 38% of college students ages 18–22 reported binge drinking in the past month compared with 33% of other persons of the same age.
- **Prevalence of Heavy Alcohol Use:** 12.5% of college students ages 18–22 reported heavy alcohol use in the past month compared with 8.5% of other persons of the same age.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2015 National Survey on Drug Use and Health (NSDUH). Table 6.84B—Tobacco Product and Alcohol Use in Past Month among Persons Aged 18 to 22, by College Enrollment Status: Percentages, 2014 and 2015. Available at: https://www.samhsa.gov/data/sites/ default/ les/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab6-84b.

HOW ALCOHOL AFFECTS THE BRAIN

Alcohol affects many areas in the brain in different ways, even with the same Blood Alcohol Concentration (BAC).

Higher centers of the brain are MORE sensitive than lower centers. As BAC increases, more and more centers of the brain are affected:

- **Cerebral cortex**
- **Limbic system**
- **Cerebellum**
- **Hypothalamus and pituitary gland**
- **Medulla (brain stem)**

Alcohol **enhances** the effects of the neurotransmitter Gamma aminobutyric acid (GABA); GABA is inhibitory, it is the brain's "downer," reducing fear, anxiety, and stress; GABA has the function of restoring a sense of calm. An increase in GABA has the effect of making you "sluggish," like you are "drunk."

Alcohol **reduces** Glutamate, an excitatory neurotransmitter. Glutamate has the opposite effect; it elicits action.

Your brain maintains a delicate balance between these two neurotransmitters

How fast the alcohol is absorbed depends on several factors:

- **The concentration of alcohol in the beverage - the greater the concentration, the faster the absorption.**
- **The type of drink - carbonated beverages tend to speed up the absorption of alcohol.**
- **Whether your stomach is full or empty - food slows down alcohol absorption.**

After absorption, the alcohol enters the bloodstream and dissolves in the water of the blood (this is your "BAC" - blood alcohol concentration).

The effects of alcohol depend on the BAC, which is related to the amount of alcohol consumed.

Your BAC can rise significantly within 20 minutes after having a drink.

EFFECTS OF ALCOHOL ON MEN V. WOMEN

Men typically have more muscle mass than women.

Since muscle tissue has more water than fat tissue, a given amount of alcohol will be diluted more in a man than in a woman.

Thus, the BAC resulting from the same amount of alcohol will be **higher** in a woman than in a man.

As a consequence, woman will feel the effects of the alcohol sooner than the man will.

Alcohol is highly toxic

Alcohol is metabolized by your **LIVER** into acetaldehyde;

Acetaldehyde is a **poison** (a cousin of formaldehyde)

It is the toxicity of acetaldehyde that causes the hangover symptoms.

The body oxidizes acetaldehyde into acetic acid, which is harmless

WHAT IS A HANGOVER?

A hangover is taking alcohol on board faster and in greater quantity than your body can break down (oxidize) into acetic acid.

From **any** health perspective, inhaling alcohol is just plain stupid!

CIRRHOSIS OF THE LIVER

- Cirrhosis is a late stage of scarring (fibrosis) of the liver; although there are many causes, the most well-known is chronic ingestion of alcohol.
- An important function of the liver is to filter your blood and remove toxins. Excessive consumption of alcohol over a long enough time breaks down healthy liver tissue and replaces it with scarred tissue. You are, in effect, chronically exposing your liver to a poison.

"SHORT LIST" OF "MILD" SYMPTOMS OF INTOXICATION:

- **Flushing**
- **Nausea**
- **Copious Vomiting**
- **Sweating**
- **Thirst**
- **Throbbing in the Head/Neck**
- **Respiratory Difficulty**
- **Chest Pain**
- **Palpitations**
- **Dyspnea** (shortness of breath)
- **Hyperventilation**
- **Tachycardia** (rapid heart rate at rest)
- **Hypotension**
- **Syncope (fainting)**
- **Marked Uneasiness**
- **Weakness**
- **Vertigo**
- **Blurred Vision**
- **Confusion**

APPROXIMATE BEHAVIORAL EFFECTS OF VARIOUS BLOOD ALCOHOL LEVELS (BAC):

.05 - .06	feelings of warmth, relaxation, mild sedation
.07- .09	more noticeable impairment, increased confidence
.08	legally intoxicated
.11- 0.12	impairment of mental processes and judgement
.14- .15	major impairment of mental and physical processes
.20- .30	loss of motor control, confusion, likely needs medical assistance
.30 +	severe intoxication, loss of consciousness and/or death

Richmond University. (n.d.). Blood Alcohol Content. Retrieved July 24, 2018, from https://www.google.com/search?q=Approximate behavioral effects of various blood alcohol levels&oq=Approximate behavioral effects of various blood alcohol levels&aqs=chrome..69i57.455j0j4&sourceid=chrome&ie=UTF-8

BAC > .20

...most people begin to experience blackouts

BINGE DRINKING

It is estimated that roughly 75% of all college students consume alcohol. In the last month, about 60% of college students drank alcohol, and about 2 out of 3 of those students engaged in binge drinking.

Binge drinking is defined as "a pattern of drinking that brings blood alcohol concentration levels to 0.08 g/dL. This typically occurs after 4 drinks for women and 5 drinks for men—in about 2 hours." (i.e., "legally" intoxicated) - National Institute on Alcohol Abuse and Alcoholism (2015)

SAMHSA. 2014 National Survey on Drug Use and Health (NSDUH). Table 6.88B—Alcohol Use in the Past Month among Persons Aged 18 to 22, by College Enrollment Status and Demographic Characteristics: Percentages, 2013 and 2014. Available at: http://www.samhsa.gov/data/sites/default /files/NSDUHDetTabs2014/NSDUH-DetTabs2014.htm#tab6-88b

SAMHSA. 2014 National Survey on Drug Use and Health (NSDUH). Table 6.89B—Binge Alcohol Use in the Past Month among Persons Aged 18 to 22, by College Enrollment Status and Demographic Characteristics: Percentages, 2013 and 2014. Available at: http://www.samhsa.gov/data/sites/default/files/ NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-89b

BLACKOUTS

Blackouts are now increasingly common among college students – blackouts are **not just observed in alcoholics.**

Duke University Survey of 772 college students:

- **40% reported a blackout within the past 12 months**
- **9.4% reported a blackout in the past 2 weeks**

DR. WHITE (2002)

"During a blackout, an individual is capable of participating in salient, emotionally-charged events but will have no recollection of what has occurred"

"Impairments in judgment, decision-making, and impulse control could lead an individual to make potentially hazardous choices during blackouts."

White, AM, et al. "Prevalence and Correlates of Alcohol-Induced Blackouts Among College Students: Results of an E-Mail Survey." Journal of American College Health November 2002

Also see: Hurlbut, SC, at al. "Assessing Alcohol Problems in College Students." Journal of American College Health April 2011

Moreover, the adolescent brain is **MORE** vulnerable to the neurotoxic effects of alcohol than the adult brain, according to Dr. White.

The Duke survey further revealed that although female students drank less heavily than male students, they were just as likely to have blackouts, which could put them at even greater risk for negative consequences, including unwanted, non-consenting sex.

SO WHAT EXACTLY IS A "BLACKOUT"?

- Blacking out is **NOT** the same as passing out.
- A blackout is a loss of the ability to have memories*, but people are still conscious when they're blacked out from alcohol. They can still walk and talk, although they may do so drunkenly.

  "You still process information. You're not anesthetized. You haven't passed out. But you're not forming new memories," - Dr. Zorumski, Washington University School of Medicine (St. Louis)

- Binge Drinking (consuming numerous drinks in a short period) is **MORE** likely to cause blackouts, amnesia and memory loss than slow, heavy drinking

WHAT CAUSES YOU TO BLACKOUT?

- It appears that the main cause of a blackout is a **rapid rise in blood alcohol**, which will be accelerated if you are drinking on an empty stomach or when dehydrated.
- When you are, in effect, forcing your body to oxidize acetaldehyde faster than it can.

As a rule of thumb,
a BAC > .15

...decision-making adequate for consenting to sex is **severely** undermined

TRANSLATING TO NUMBER OF DRINKS:

6 drinks	7-8 drinks	10 drinks
BAC = 0.12	**BAC = 0.15**	**BAC = 0.20**
Vomiting	Point at which you have trouble walking straight	Blackouts & Memory loss

WHAT IS ANTABUSE?

- Antabuse is a prescription medication that is used in the treatment of Alcoholism. It creates a very unpleasant and serious reaction if you drink alcohol when on the medication.
- [To recap: Alcohol is metabolized by the body into acetaldehyde, **a very toxic substance** that causes the hangover symptoms. The body oxidizes acetaldehyde into acetic acid, which is harmless]
- Antabuse interferes with this metabolic process, stopping the oxidation of acetaldehyde into acetic acid, causing a build up of toxic acetaldehyde 5 to 10 times greater than normally occurs when someone drinks alcohol.
- Antabuse, in effect, produces a very **severe** hangover.

BARBITURATES

WHAT ARE BARBITURATES?

- Barbiturates are sedative and sleep-inducing drugs
- Barbiturate intoxication is similar to alcohol intoxication
  - **Similar withdrawal symptoms**
  - **Sedate - relieve stress & anxiety**
  - **Increase sociability & good-humor**
  - **Users experience lack of coordination, ataxia (i.e., lack of muscle control for voluntary movements), & slurred speech**

- There are over 2,500 barbiturates.
- Intoxicating doses of the more popular ones last about 4 hours.

Generic Name	Street Name
Amobarbital	Downers, blue heavens, blue velvet, blue devils
Pentobarbital	Nembies, yellow jackets, abbots, Mexican yellows
Phenobarbital	Purple hearts, goof balls
Secobarbital	Reds, red birds, red devils, lilly, F-40s, pinks, pink ladies, seggy

COCAINE

WHAT IS COCAINE?

Cocaine acts as a powerful sympathomimetic agent; it potentiates the effects of sympathetic nerve stimulation, producing a dose dependent increase in blood pressure and heart rate, as well as a rise in core temperature, partly because of increased muscular activity and partly because of vasoconstriction (constricted blood vessels).

Smoking (as opposed to snorting) also known as freebasing allows extremely high doses of cocaine to reach the brain very quickly and brings an intense and immediate high.

Cocaine and Alcohol taken in combination has a longer duration of action in the brain and is more toxic than either drug alone.

Cocaine and Alcohol is one the most lethal drug combinations.

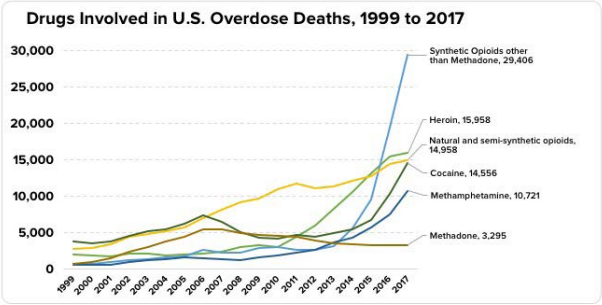
Others include: Alcohol and Opiates, Alcohol and Benzodiazepine, Cocaine and Heroin.

https://drugabuse.com/library/infographic-most-dangerous-drug-combinations/

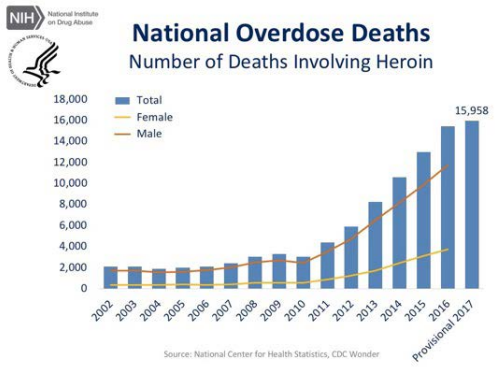
RECENT TRENDS

SIGNIFICANT INCREASES IN:

- Opiate abuse
  - **Prescription pain killers (e.g., oxycodone, oxycontin, Vicodin)**
  - **Heroin**
  - **Fentanyl**
  - **Impact includes overdose, death, increase in diseases such as HIV and Hepatitis due to sharing dirty needles**
- New synthetic drugs (e.g., synthetic marijuana) with deleterious effects and death .
- Adverse reactions and death



Among the more than 72,000 drug overdose deaths estimated in 2017, the sharpest increase occurred among deaths related to fentanyl and synthetic opioids with nearly 30,000 overdose deaths (68% of all overdoses). - National Institute of Drug Abuse



From 2002 through 2017, there was a 7.6-fold increase in the total number of heroin related deaths.

DRUG FACILITATED SEXUAL MISCONDUCT

WHAT IS ROHYPNOL?

- Rohypnol is the most common drug to incapacitate a victim for Sexual Misconduct.
- Many street names: **Roofies, Rophies, Roche, Forget-me Pill, Circles, Mexican Valium, Rib, Roach-2, Roopies, Rope, Ropies, Ruffies, Roaches.**
- Rohypnol is also simply referred to as the "date rape" drug.
  - Drug Enforcement Administration, Resource Guide, 2017

- Because Rohypnol is tasteless and odorless, it is slipped into an unsuspecting person's drink at a party or a bar, and then sexually assaulted when they're too 'out of it' to protest, defend themselves or say "no"
- Rohypnol is a **benzodiazepine** (Flunitrazepam)
- It is sold legally in Latin America & Europe as a short-term treatment for insomnia and as a pre-anesthetic.

TO BE CLEAR:

- In the United States, it is illegal to manufacture, sell, use or **be in possession** of Rohypnol.
- The US government passed a law in 1996 known as the Drug Induced Rape Prevention and Punishment Act . The law allows anyone convicted of drug-related sexual assault or rape to receive more severe punishments such as longer prison sentences and higher fines.
- Rohypnol carries the same penalties as other Scheduled I drugs, such as heroin, Ecstasy and LSD.
- **Simple possession of Rohypnol can result in a prison sentence (typically up to 3 years) and a fine of no less than $5,000. Penalties differ from state to state.**

- **Symptoms**: Drop in blood pressure, drowsiness, visual disturbances, dizziness, confusion, GI disturbances & urinary retention. Similar sensations as intoxication, but consumption will not result in a hangover the next morning.
- **Myth**: Rohypnol cannot be detected in a urinalysis.
- **It CAN be detected**: (2-milligram doses can be detected within 72 hours of ingestion), it does break down very quickly, however, many commercial toxicological screens do not detect it.

- Physiological effects very similar to Valium (diazepam),
- but Rohypnol is approximately **10 times more potent** than Valium.
- A similar drug is Klonopin (clonazepam).

WHY ARE "RAPE DRUGS" USED TO FACILITATE SEXUAL MISCONDUCT?

- **MOST significant effect of the drug is anterograde amnesia.**
- Anterograde amnesia is a condition in which events that occurred while under the influence of the drug are forgotten
- Strongly contributing to its inclusion in the Drug-Induced Rape Prevention and Punishment Act of 1996.

POTENTIATION WITH ALCOHOL

- In combination with alcohol, Rohypnol is especially dangerous!
- Intoxication from Alcohol & Rohypnol can result in "blackouts" lasting 8 to 24 hours following ingestion.
- Effects on memory and judgment are greater than the effects resulting from either taken alone.
- Effects begin within 30 minutes, peak 2 hours, and can persist for up to 8 hours.

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IMMEDIATE EFFECTS OF ROHYPNOL

- About 10 minutes after taking Rohypnol, you feel dizzy and disoriented, simultaneously too hot and too cold, and / or nauseated.
- You may experience difficulty speaking, slurring your speech, and difficulty moving before passing out.
- Victims typically have no memories of what happened while under the influence of the drug.

WHAT IS GHB (GAMMA-HYDROXYBUTRATE)?

- Many street names: **Liquid Ecstasy, Somatomax, Scoop, Grievous Bodily Harm, Georgia Home Boy, Liquid X, Liquid E, G-Riffick, Organic Quaalude, and Easy Lay**
- Since about 1990, GHB has been sold on the street as a euphoric, sedative, and anabolic (bodybuilding).
- As with Rohypnol, GHB has been associated with sexual assault throughout the world.

GHB EFFECTS:

- Effects are highly dose-dependent.
- There is a steep dose-response relationship (i.e., small increases in the amount taken lead to significant intensification of the effect).

EFFECTS SIMILAR TO ROHYPNOL:

- Amnesia & Hypotonia*
- High doses can decrease cardiac output, depress respiration, and produce seizure-like activity and coma.
- High doses also produce giddiness, silliness, verbal incoherence, dizziness, and eventually sleep.
- Sufficiently large dose can produce “sudden sleep” in about 10 minutes.

* abnormally low muscle resistance to movement

IS GHB LEGAL?

- It is a “Gray” Market
- It is currently regulated in the US and sold under the name Xyrem,
- On the street, it is a bootleg drug (produced, distributed & sold illegally).

WHAT IS BURUNDANGA?

- Burundanga is called “voodoo powder.”
- It comes from a Colombian plant of the nightshade family, a shrub called barrachera, or "drunken binge."
- The powder causes those who ingest it to “lose their will”(e.g., drowsiness, loss of inhibition, inability to restrain oneself) and memory for past events, sometimes for days.
- Like the stronger benzodiazepines, it can induce retrograde amnesia.

- Spanish discovered Burundanga when they invaded Columbia in the 17th Century: **“the tree that drives people mad.”**
- For past 20 years, burundanga has become the most troublesome drug used in crime, primarily sexual assault and robbery.
- **A young American woman visiting Bogata was raped by 7 different men with no memory of the crime.**
- Under the influence of Burundanga, people have been ordered to release passwords, empty bank accounts, and engage in sexual acts without their knowledge.
- Traded as currency in immigrant-criminal and illegal-alien- criminal markets.

OVERVIEW OF “DATE RAPE” DRUGS:

- **Rohypnol - benzodiazepine**
- **Burundanga - cholinergic blocking agent**
- **GHB - CNS depressant**
- Possession and use is a crime; unlike alcohol, the use of one of these drugs is likely to be used in connection with sexual assault. Bringing one of these drugs to a party can be evidence of premeditation to create a crime.

POWERPOINTS

Groupthink

Principle Contributors: Prentky, Righthand, Lamade, & Lopez

Group Think:
Why We Act Like Sheeps

Recommended for Module 3

STARRSA | Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- Definition of Groupthink
- How Groupthink has caused egregious social consequences
- Why Groupthink is a problem

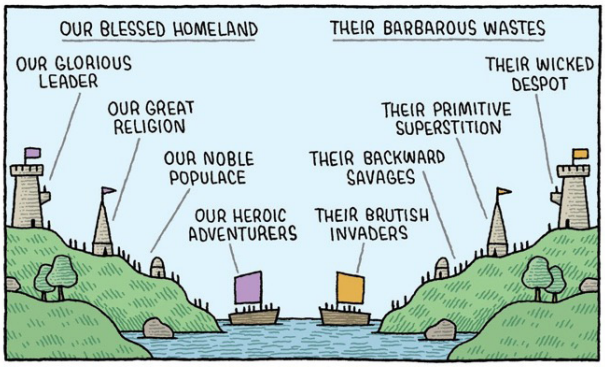
What is Groupthink?

- Animals travel in herds, mostly for protection from predators; even many predators like lions hunt in "herds."
- *Herding is an adaptive strategy that once protected us from threats.*
- Our Palaeolithic ancestors lived in caves in groups, for hunting and for protection from other marauding hominids and beasts of prey.
- Groups still serve an important role for modern day "cave dwellers."

- George Orwell's book (1949) "1984" or Nineteen Eighty-Four introduced terms like Big Brother, "doublethink," "Newspeak, "crimethink" and Room 101.
- Irving Janis' (1982) classic *Groupthink* described a way of thinking among people deeply entrenched in a cohesive in-group.
- *Groupthink* - reflects a breakdown of independent thought, independent reality testing, and loss of moral judgment – *all resulting from group pressures to conform.*

Today, it is "Tribalism"

- What used to be reserved for the customs and beliefs of a "tribe,"
- Has now taken on new meaning - strong loyalty to one's own "tribe," with tribe referring to one's own political party or ideological group.
- **Groupthink is now Tribethink.**



In extreme cases, Groupthink leads to a loss of ability to think for yourself.

("mindmeld" with the group)

POP CULTURE: MIND MELD

- The title of the film referred to Spock's (from Star Trek) telepathic ability to communicate with other (alien?) organisms because he is part Vulcan.
- ***Mind Meld: Secrets Behind the Voyage of a Lifetime*** -- a 2001 American film in which actors William Shatner & Leonard Nimoy discuss Star Trek.

"TOXIC TRIBALISM"

- Obedient, unthinking devotion and commitment to your group's narrative can reach a toxic level that includes "demonization" of those who question your narrative, with name-calling, and labels such as stupid, scum, evil, racist, etc.
- Toxic Tribalism (tribalism at its worst) is primitive and reflects an instinctive hostility for those of another tribe, race, religion, nationality, class, gender, political or ideological persuasion, etc.

Who should know better than Friedrich Nietzsche, the German philosopher who famously declared that: "God is Dead"

- "The individual has always had to struggle to keep from being overwhelmed by the tribe. If you try it, you will be lonely often, and sometimes frightened. But no price is too high to pay for the privilege of owning yourself."

An extreme example of Groupthink is a cult...

such as Charles Manson's "family".

The need for conformity and acceptance by the group overshadows all capacity for independent thought.

WHAT HAPPENS WHEN YOU STAND OUT?

- You lose your "cover," your sense of invulnerability conferred by the group.
- You "expose" yourself as different, often in a way that is not positively received.
- Reactions may range from suspicion to fear – in ancient terms you have become a possible marauder, a threat to the in-group – a threat to what everyone in the group believes – or at least what everyone in the group thinks they believe simply because everyone else seems to believe it.

Communal "wisdom" of the group often works

- Silver (2012): "The heuristic of 'follow the crowd, especially when you don't know any better' usually works pretty well."
- Like most heuristics that serve us well most of the time, groupthink can on occasion be catastrophic.
- Silver (2012): "The blind lead the blind and everyone falls off a cliff. This phenomenon occurs rarely, but it can be quite disastrous when it does."

One of the obvious & extreme examples of a "disastrous" outcome

- Holocaust – systematic extermination of 6 million European Jews following Adolph Hitler's "Final Solution to the Jewish Question."
- So widely adherent was the narrative, that "Not one social group, not one religious community, not one scholarly institution or professional association in Germany and throughout Europe declared its solidarity with the Jews."
  - Saul Friedländer

Closer to home, in the United States, groupthink paved the way for and insured the life span and disastrous consequences of numerous morally bankrupt social narratives:

- 350 years of murder, torture and slavery of African- Americans
- Near extermination – of all indigenous (Native) Americans
- McCarthyism and the "witch hunts" for "communists"
- Salem trials of "witches"

These are all such extremes - How does it work at a campus party when everyone is just having a good time?

One or two dominant ("alpha") males get the idea that having a good time should include sex – which is perfectly ok. After all, everyone enjoys sex and that includes women, right?

The problem...

- arises when those alpha males decide that the best way to do it would be to get the women sufficiently drunk or drugged that they don't know or can't protest when their clothes are being removed.
- At that point, if any "black sheep" at the party stands up and says to the alpha males, "You fuckin' kidding man? What are you doing? That's rape." He would immediately be drowned out in a chorus of inflammatory insults, charging the black sheep with being a cock blocker – or worse...

Game on...

- Used to refer only to a competitive sports event
- Now it refers to getting sex, and anyone that "interferes" will be denigrated and ostracized as a cockblocker
- It the "narrative" of the group, sometimes among frat brothers, sometimes among members of an athletic team, sometimes just a group of buddies out for a good time

In that context, standing up for what you believe takes courage, the kind of courage that only a real man has.

Standing up for what you believe isn't always easy, sometimes it's downright hard, but it IS what a real man does – not a wimp that goes along with the group.

Fictional male heroes in the movies stand solid ground for what they believe in – and are unmovable no matter what wrath is leashed upon them.

Standing your ground takes courage of your conviction; whatever words come to mind for you, "backbone," moxie, tough, grit, iron will, resolve, fortitude, etc., the one thing that characterizes ALL of them is that they are "heroic" for saving victims, NOT for creating victims.

Can you think of a single "hero," real OR fictional, that is known for creating victims?

POWERPOINTS

Negative Masculinity

Principle Contributors: Prentky, Abrahms, Righthand, Lamade, & Lopez

Negative Masculinity

Recommended for Module 5

STARRSA Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- Definition of Negative Masculinity
- A review of attitudes that support negative masculinity and attitudes that support hostility towards women
- A discussion of "what it means to be a man" in today's society

Before talking about what is "negative" about masculinity, lets talk about what is positive!

From the outset, let's be crystal clear:

- There is nothing inherently negative about masculinity!
- Growing up to be a strong, young man with confidence,self-worth and drive to excel and succeed in life is a wonderfulthing; sex is a wonderful thing; being a prized successful athleteis a wonderful thing!

So with that in mind, let's turn to the question of what negative masculinity is, what it "looks like," perhaps where is comes from, and perhaps what it can do to others.

WHAT IS NEGATIVE MASCULINITY

Stereotypic attitudes, beliefs, and behaviors associated with masculinity, what it means to be a man in our society, and with male-female interactions, including the hallmark of sexual entitlement.

WHAT IS NEGATIVE MASCULINITY?

- risk-taking
- defending one's honor above all else
- belief in the illusion that men are "superior" to women
- and that men are "dominant" over women
- denying male "weakness"
- sex as a birth rite for manhood
- symbols of toughness, fearlessness, insensitivity to pain
- emotionally stoic / indifferent to emotion
- male bonding around masculine "themes" (e.g., sports,hunting, pro-sports, etc.)

IN DEFENSE OF ONE'S HONOR

- A central theme in defending one's honor often relates toinsecurity about one's manhood and a hypersensitivity toperceived threats to one's manhood.
- It could be as simple, and nothing more consequential, then youand another guy pursuing the same girl, and the girl choosing togo out with the other guy.
- It becomes more than a simple disappointment (she does, afterall, have the right to date whomever she wants). It "feels" asthough it goes directly to your "worth" as "a man." He was "moreof a (desirable) man than you.
- Rarely do you get angry at the guy. He "won," as if it werecompetition. The next day, you might ask him with a wink "sohow was she"? But you may well be angry with her – she dealt ablow to your self-esteem as a man.

PROFESSOR MALAMUTH'S CONFLUENCE MODEL

Dr. Malamuth proposed a two-path model in which:

(1) negative masculinity and

(2) impersonal sex

were the major predictors of sexual aggression

ASSESSMENT SCALES

Many scales have been developed that assess a variety of beliefs, such as the adversarial nature of men's relationships with women, stereotypical ideas about sexual roles, negative notions about "real" masculinity, and myths that support sexually aggressive behavior.

In a meta-analysis examining 11 different measures of masculine attitudes from 39 studies, Murnen et al. (2002) found:

that all but one measure of masculine attitudes were significantly associated with sexual aggression, and **the strongest support was for negative masculinity & hypermasculinity**, both of which assess hostile beliefs about women, the need to be in control, and an acceptance of violence against women.

TO BE CRYSTAL CLEAR

- There is NO direct link between our beliefs and attitudes and our behavior.
- We all think things at times that we would never act on!
- What we believe, however, IS important; it interacts with many other factors to determine our behavior:
  - circumstances (e.g., being at a party)
  - opportunity (having many women present that are there to party and a good time)
  - peer encouragement or "peer pressure,"
  - booze (plenty to disinhibit you – and the women)
  - and of course it helps to think the "right" thoughts

Some of these beliefs & attitudes are on the next 2 slides; see if any of them sound familiar.

A FEW SELECTED ATTITUDES OR BELIEFS SUPPORTING NEGATIVE MASCULINITY FROM VARIOUS SCALES

- **I am known by my friends as a tough guy**
- **I've taken risks plenty of times in my life**
- **I believe women are really only good for one thing**
- **I can take a beating as well as any man**
- **I never let another guy get one up on me**
- **I would beat up a guy who insulted my girl**
- **I can hold my own with anybody when it comes to drinking**
- **I have destroyed things just for the hell of it**
- **When it comes to satisfying a women, I am better than most**

SELECTED ATTITUDES AND BELIEFS SUPPORTING HOSTILITY TOWARD WOMEN

- **Many women seem to enjoy putting men down**
- **A husband should never let his wife manage the money**
- **You can never win an argument with a woman by just talking**
- **Most women are cold people**
- **If they had the chance, most women would run around on their husbands**
- **A man should never tell a woman how he really feels about her**
- **There are a lot more ugly women than there are pretty ones**
- **There are some times when a husband should hit his wife just to remind her who is the man**

- In sum, we are talking about a set of deeply ingrained core beliefs and attitudes about women, about sexuality, and about relationships that are hostile, demeaning, and degrading to women. This is the foundation of negative masculinity.
- As noted, these attitudes and beliefs are often firmly held, frequently because they have been reinforced by a culture that supports such attitudes as normal.

So what do these attitudes tell us?

- In truth, these beliefs or attitudes tell us nothing about women
- They tell us about men and their struggles with masculinity and "feeling" masculine
- They tell us about the larger problem of feeling insecure about our manhood, insecure about "being a man"

- If these attitudes are "normal," they must, after all, be ok – it's what everyone I know thinks …. so the thinking goes ….
- **These attitudes are directly expressed and indirectly reflected or implied by the marketing and advertising industries, in professional sports, in movies, by many politicians, shock jocks, and even judges**
- That is what we mean by a "culture" that condones, and in some cases actually promotes, sexual violence toward women

So if what I think about masculinity is "negative," what is "positive" masculinity?

- What can make masculinity "negative" is often a byproduct of our culture; it begins with how we were raised, what we were taught by our principal male role-model – our father or step-father, what we heard from our peers that we chose to hang around in the school yard, both as a juvenile and eventually when we went off to college; these beliefs are then reinforced by the drumbeat of the media we choose to listen to.

STANDARDS TO BE A "REAL" MAN

- We are left with what feels like our "marching orders" in order to be a "real" man – whatever that is.
- These "real" men are often our sports heroes, the high profile guys on the high school gridiron – same in college; the guys on the covers of men's magazines, the guys in the movies that defeat entire enemy armies single-handed, perhaps your own father – a war hero. In high school especially, these were the guys that "got the girls."
- You weren't celebrated – by your peers (guys or girls) for being a wizard at chess, for being the lead in the senior play, for being a master debater on the debate team, for being the fastest long distance runner on your cross-country team, or for being on track to be the valedictorian.

I remember clearly after all these years how it "felt"

- As a member of Group 2, I did "ok" with the girls, not like the guys that had 2 or 3 (or 4!) varsity letters on their sweater that they gave to their cheerleader girlfriends. But I was still a member-in-good standing of their tribe – surfing was "cool," I was one of the very few rock climbers and that was seen as cool (anything risk-taking is likely to be cool), swim team, track team, cross-country – it was enough for membership...
- but I befriended a few of the guys in Group 3, mostly through scouts, and I came to learn how "painful" it was to be so "discounted" as guys, to be labeled as dumb, as car monkeys, as "losers." It had an enormous impact on their self-esteem, in terms of their intellect, in terms of their "prospects" for success, and of course in terms of their success with girls.
- They were, in a word, demoralized as young men. And they deeply resented that the only girls that would pay any attention to them were the girls no one wanted to date (i.e., the girls in the girl-equivalent of Group 3).

- Meanwhile, the guys in Groups 1 & 2 did ok. The nerdy guys hung out with the nerdy girls; their self-esteem was defined by their academic achievements and their future professional plans. The "cooler" guys in Group 2 found self-esteem in the more traditional pathways to manhood tempered by some realistic appreciation of the need to plan for their future.
- They both had room to develop a reasonably healthy sense of self-esteem and self-worth,

Let's try to delineate what high self-esteem looks like:

- **Competition and a Sense of Humility** – when you strive to play at the top of your game (in the classroom, in athletics, in the workplace, etc.) you face competition – sometimes fierce competition; competition teaches you that you are not the best, that you need to work hard to reach the top; arrogance, egotism, conceit, boasting / bragging, superiority – all are the death knell for success – the antithesis of humility. More than anything, as a kid, rock climbing taught me humility – hanging out in Yosemite, watching the world's best climbers do things I knew I was incapable of.
- **Competition, above and beyond all else, builds self-confidence and a sense of mastery.** But confidence and humility are NOT mutually exclusive. Real self-confidence is the opposite of arrogance! Real self-confidence is knowing your strengths and your weaknesses, being proud of your strengths and acutely aware of your limitations.

- Humility is NOT being a braggart. Braggarts are blowhards or gasbags or grandstanders; they have nothing to "inside" themselves to offer, so they brag. Bragging is deluding yourself and trying to delude others.
- It can be dangerous! When I agreed to take the lead on a difficult climb, I was clear that my skills were adequate to take on 5.8 route.* If the route was rated any higher, and I ignored by limitations, I would be putting myself and my climbing buddy in potentially serious harms way.

**the Yosemite rating system for route difficulty is much different today!*

- **Being accountable for what you say and what you do.** In a word, taking responsibility for not just what you say but for your behavior. No excuses, no finger-pointing, no blame directed elsewhere.
- **Integrity.** Possessing a good moral compass is the sign of honor. Honor is what, in truth, we esteem in our most revered heroes (and heroines) - being honest, truthful, and fair; it becomes a difficult bar to hurdle with low self- esteem, since we are confronting our limitations and frailties along with our gifts, our expertise, our skills, our genuine accomplishments.
- **Loyalty.** Loyalty is often akin to having integrity and honor. Loyalty implies fidelity, honesty. Loyalty implies far more than waving or flying the flag. Loyalty is a bond, a duty, a fealty, a devotion to a common good. Above all, it means dependability – you can be trusted by others. It is why Loyalty, Honor and Sacrifice is the common creed of the Marine Corps.

- **Living in the present!** - Not dwelling upon or living in the past (or in the future - not obsessing about "what if."
- **Being able to express ourselves** - (1) without fear of rejection, and (2) without any intent to harm others – ever.
- **Being able to recognize, manage and properly express our emotions,** such as anger, fear, guilt, sadness, rejection, jealousy, etc. Emotions are human and deserve to be expressed – without hurting others.
- **Not fearing uncertainty** – none of us are perfect! Perfection is not attainable (or even desirable). A commitment to doing the very best we can is all that we can (and should) expect - ever.
- **Resilience and Perseverance** - the most successful people do not sail through life free of storms; they have numerous setbacks, sometimes unimaginable hardships, but they persevered; with high self-esteem, during the inevitable storms in life you able to cope, minimize the impact and forge ahead

- **Feeling in control of your life** – Resisting the temptation to believe that external forces (your job, your boss) or circumstances (your upbringing) are such that you have no control. Absent a sense of control, we give up. Retaining a sense of control over our lives enables us to take responsibility for our lives and do the best to improve our lives. We don't blame the outside world, other people, or circumstances.
- **Not following the followers** - having the confidence to think for yourself and arrive at your own conclusions, your own beliefs, and not accept automatically whatever the tribe (or herd) says – ever.

The confidence that comes with healthy masculinity means using your power and your strength and your conviction for the right reasons.

- It means standing up for the underdog, **not** taking advantage of the underdog.
- It means standing up for victims and, if necessary, protecting victims, **not** creating victims.
- Men of honor & integrity do not create victims.

***Healthy masculinity is not equated with heroism – putting yourself directly in harms way to save a victim. We have "heroes" that do that. Most of us don't, and we are not less a man for it. What we do not do is create victims.**

- In the fictional world, our heroes and super-heroes protect victims, and in the real world, we pay our greatest homage and our greatest respect to those heroic souls that defy all odds to protect those in danger (e.g., "9/11").
- With some obvious very sad and unfortunate exceptions, we do not honor those who intentionally harm others or put others in danger!

- With the obvious exception of presidents in times of war, can you think of just one instance in which we, as a society, paid homage to those that intentionally place others in danger or harm's way? **Just to ask the question sounds ridiculous.**
- We revere and honor our servicemen who lay down their lives to protect us from harm posed by others.
- Those who harm others do not deserve respect or honor; in fact, we often call them offenders.

- Having **internal strength**, fortitude, backbone, moxie, grit, mettle, valor, tenacity, courage, or whatever you wish to call it, are characteristics of strong, prosocial men who stand firm for what they believe in.
- It takes considerable courage to look yourself in the mirror and own who you are, for all your strengths **and** your weaknesses.
- It takes courage and honesty to look yourself in the eye and ask whether you are proud of the decisions you have made.

The only example of a "heroic criminal" that comes to mind was Robin Hood; He stole from the wealthy, but he returned the "proceeds" of his theft to the poor – at least according to legend!

- Puffing out your chest filled with little more than hot air is what clowns do in the circus.
- It is also what narcissists do. They puff themselves up to compensate for all their inadequacies.
- Healthy self-assured men have **no need** to brag, no need to boast, no need to be arrogant.

MELTING THE DIVIDE BETWEEN MEN & WOMEN

- How do we melt the artificial divide imposed by rigid attitudes and beliefs about who ("real") men are and who ("real") women are?
- The traits that we so prize in some men, are clearly observable in some women, and those same traits are only minimally observable or absent in some men.

KEY:

- We have heroic males in fictional roles because that package of traits we so prize and pay homage to are not present in the vast majority of men!

- By shrinking the rigid dichotomy of who "men" are and who "women" are we begin to overcome the "dis-similarities" that make women "strangers" to men.
- John Gray's (1992) book Men are from Mars, Women are from Venus speaks to this "divide." It's a silly book, but the title has become a part of pop culture.
- **Most important among these false gender divides are many of the same characteristics that define manhood, such as grit, stamina, perseverance, courage, tough, competitive, etc.**

- Our goal should be to adopt male role models that exemplify all of the traits of what it means to be a strong prosocial man with prosocial values and the self-esteem to fight for those values.
- Remember, most of us actually fall all along a continuum with respect to those traits that we admire and even envy – and – amazingly, most of those same traits fall along a continuum among women as well

Check out this somewhat amusing description of our rather twisted conception of what it means to be a man:

Sacked by the Media Blitz

Dana Jennings, NYT, Sunday, 11/24/2013, p. 20

from a column written by Dana Jennings about the ads during the NFL telecasts

"...we are about to plummet once again into a rambunctious world where the men are mainly brainless, oversexed galoots who can't overcome their lusts or their superstitions. In other words: the Dark Ages live!"

"...the marketers think they know the men who are watching – and it is still mostly men – and what their deep-down desires are: tank-like trucks, Arctic-cold beer, smoldering chicks (and the occasional pizza)"

"...the modern Mad Men seem convinced that watching attractive women shake their bikinied assets will make us drool over a Fiat 500L. That we really long for a car, say, the Cadillac XTS, that literally blows the doors off everything else on the road. And that maybe we're such drunken flat-liners that we don't know that the more a beer tastes like wolverine urine, the bigger its ad budget."

"Anyway, here's the bottom line in most ads: male insecurity. That manly frailty is an emotional Stradivarius bowed expertly by spots for trucks and E.D. aids [erectile dysfunction]: "Really son, you sure you're man enough to get behind the wheel of a Durango, Tundra, Sierra, Silverado, or a Ram? (it's got a Hemi under the hood, y'know). We usually only sell these son-of-a-buck pickup trucks to cowboys, steelworkers, and roustabouts."

What we think, and what we believe drives our behavior.

ON CAMPUS

For present purposes, we can reduce what it means to be a "man" to one simple word: Scoring

- A key part of what it means to "be a man" at college is having lots of sex! With lots of women. Only with women, however. Never with other guys or folks of other gender identities. and ideally with "cute chicks" – the ones that all men drool over – you know the ones – the leggy blonds.
- Game on! It's about scoring! The game of scoring is tallying as many "cute chicks" as you can have sex with as possible – the singular goal is to get laid! Getting laid defines one's manhood. Getting laid deserves a "high 5" Getting laid deserves the admiration of the other guys who didn't "score."

Sexual "Conquest" becomes a Game

- Now let's be perfectly clear, there is nothing wrong with having lots of sex! But when men set their self-worth and self-esteem on how much sex they are having just to keep their "man card"–we have two problems:
- First, sexual conquest is a predatory game; the guys are playing a game with a bunch of "rules" about how to win; winning means getting laid. So the rules are tactics about how to get laid. **These rules have nothing what-so-ever to do with the wishes of women – it's a one-sided game:** How to get into as many women's pants as possible and avoid any hassles along the way.

CONSENT?

- All of this stuff about "consent" just becomes a nuisance – an obstacle in your path, something to ignore or get around or just "finesse."
- Guys are, in effect, "using" women to bolster their credentials, their bona fides, as real men. And with it, their self-esteem.
- This strange game normalizes a culture where men are expected to do whatever they can to "get" sex. "Sex" is a game where the goal is a high score and the women, well, they're just necessary obstacles that need to be overcome in order to get a high score.

WE SAID THERE WERE TWO PROBLEMS

- The first is "using" women as objects to make you feel more of a man, to reinforce your manhood, creating a huge number of victims along the way.
- Second: The second problem is the denigration of what it means to be a man. The "standard" that the more times you get your penis into a different vagina the more of a "man" you are is a pathetic, pitiful, and wholly inadequate measure of masculinity. **It reduces men to little more than sexual con artists.**

- Recall discussion about who our real heroes are, who our fictional heroes are, who the men are that we esteem as our greatest role-models:
- Can you think of one that you would characterize as a sexual con artist?
- It's hard, because, interestingly, most of what we know about our heroes – both real and fictional – has nothing at all to do with sex

- How would it make you feel more like a man when you had to get the women drunk in order to have sex with her?
- Why use alcohol? Just hit her over the head with a club?
- Isn't that what the early cavemen did? Hardly seems like much of an improvement over the last 30,000 years!

THE SET UP

Moreover, it sets men up for highly risky sex when the "rules" for winning include coercive tactics that cross the line into criminal behavior.

When you feel peer pressure "mounting," because your score card provides meager evidence of scoring, you may resort to tactics that cross the line to sexual misconduct.

With many men "out to score," it places the burden of preventing sexual misconduct squarely on women – women must in effect protect themselves from men. It sure takes all of the fun and all of the pleasure out of sex!

What pleasure is there in having sex with someone that is unconscious? The ONLY pleasure comes from the high-fives you get the next day.

The sex itself was meaningless.

(and in your private thoughts, you know it; you just would never admit to the guys)

Now it's your turn to think critically about how this "norm" plays out in your life.

- How much pressure do you feel to conform to the norm?
- How much pleasure did you feel at the time?
- How much pleasure did you (really) feel the next day?
- How truthful were you (really) when you told the guys the next day about your "score"?
- Did you ever lie – just a bit, you know, like when you said it was a home run but you didn't made it past 3rd base?

POWERPOINTS

Sociocultural Context

Principle Contributors: Prentky, Righthand, Lamade, & Lopez

Sociocultural Context

Recommended for Modules 3 & 5

STARRSA | Science-based Treatment, Accountability and Risk Reduction for Sexual Assault

A Project Funded by the United States Department of Justice Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking

TOPICS COVERED

- Media's Portrayal of Women (1950's – Today)
- Case examples of sexual misconduct
  - In high schools
  - In the criminal justice system
  - In the media
- Discussion of "rape culture"

MEDIA'S PROTRAYAL OF WOMEN

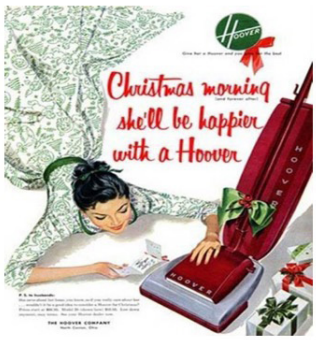
1950's – 1970's

Not very bright but teachable.

Not very bright but teachable.

The Woman's Role? The House Maid.

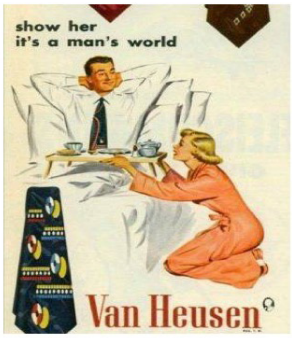
The house maid would love nothing more than a vacuum cleaner for Christmas.



Cooking: "that's what wives are for!"

House cleaning has another advantage: "keep down your weight".

A Van Heusen tie will "show her it's a man's world": her knees in reverence – or supplication.



Apparently it is so "manly" to blow smoke in a woman's face, "she'll follow you anywhere".

If she fails to "store-test" your coffee for freshness, throw her over your knee and spank her.

Your Subaru: "...like a spirited woman who yearns to be tamed"

Perhaps it not "illegal" to kill a woman if she engenders your anger by embarrassing you with your postage meter.

MESSAGES FROM 1950'S ON:

- Women are not very bright, but they are trainable
- It's a man's world and they need to know their place
- Occasionally they may need to be "tamed" or spanked to be kept in line (or perhaps trained)
- Their role is cooking and house-keeping

Today, women "serve" a different purpose for men.

Women are used primarily as sexual objects to sell brand name items.

Fast forward 60 years.

The following ads convey with equal clarity this new set of messages about women.

The woman of the house is no longer expected to cook as long as she wears her Wonderbra when "her man" comes home.

Message: I can't cook – but hey what man would care?

Asonor is an anti-snoring device. The wife in curlers will do anything to keep her man from snoring, including providing him with a lovely playmate.

Ad for French Fries: Does anyone notice the French fries? The fries are "real," anything else you are looking at isn't. "Real Fries in a Fake World."

A little oral sex (implied) with your "super 7 incher"?

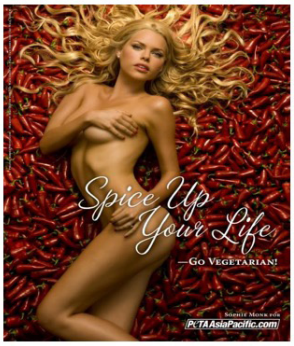
Even an ad from Nikon:

Ad for Lynx Shower Gel:

Ad for JBS Men's underwear:

Ad for "Flirt" Vodka: implied oral sex.

PETA Asia is an animal rights group:
featuring a naked woman on a bed of hot peppers?



These messages are far simpler than the messages from the 1950's.

These messages have nothing to do with women's intelligence or their role in life.

There is only 1 simple message: women are sex objects for men.

Women's roles in the 1950's:

- cooking / keeping the house
- bearing and raising the children
- keeping your husband satisfied

Women's role by 2018:

- sexual objects

What influence does this marketing blitz have on sexual assault?

Objectification of women as sexual objects.

The principle is pretty simple…

What we think, what we believe – our attitudes simply stated – can influence our emotions and drive our behavior.

Please pay **close** attention:

FOR MEN, IT IS EQUIVALENT TO SAYING THAT YOUR WORTH AS A "MAN" IS DETERMINED BY:

- Your clearly defined pectoral muscles
- Your "six-pack" stomach / abdomen and small waist
- The larger "size" of your penis
- Your broad shoulders
- Your height – taller is always better
- Facial dimorphism: faces that are more square with sharp features, and stronger, more defined jawlines, with NO beard, just a "5:00pm shadow"

WHY?

- Because that is the "physical equivalent" for a man as you just saw in the pictures with the beautiful models
- Those female models no more reflect the norm for women than the physical characteristics you saw reflect the norm for men

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THE VAST MAJORITY OF MEN WOULD NOT TAKE KINDLY TO BEING "REDUCED" TO:

- The lack of a contoured stomach
- Excessively narrow shoulders
- Poorly defined chest & "pecs"
- A penis that didn't "stand-up" to expectation
- A face that was, well, shall we say, unmemorable, too round, too pudgy, too poorly proportioned
- And a man, well, sorry, just not quite tall enough

BUT THE MESSAGE IS SIMPLE

- Women exist to provide for Men's sexual needs; that is their principle role or purpose in life
- That is the **essence** of **Sexual Entitlement**
- Message: I am entitled to have sex because I am a Man; it's just part of being a Man; you don't have the right to say "no" or to question it, because I am entitled to have sex.

What if the clear message was:

Men exist for only one purpose: to be workhorses for women.

So what's the big deal about looking at beautiful women?

NO BIG DEAL:

- No bigger deal than women looking at pictures of gorgeous guys! We ALL do it! We all look at gorgeous women and men and fantasize.
- The problem arises when, as a guy, you are reduced to nothing more than your physical dimensions, your body, your facial attractiveness, your ability to keep an erection for 5 hours like the studs in the porn movies... in one word, you're not, by some arbitrary standard, "HOT."
- You're damn straight! You'd resent it! You'd want to say, "I'm really a nice guy, I'm smart, I'm considerate. I'm thoughtful. I do really well in school. I'm a pretty good athlete, even if I haven't won trophies, I'm not bad looking, even if I'm not model...
- You would resent being "objectified" for nothing more than your physical appearance.

When we take objectification one step further:

It can lead to dehumanization: You are nothing more than an "object." At that point, you are no longer even a human being.

Dehumanization can lead us to commit horrific crimes against others, because, simply, the victim is less than a human being

One of the most infamous such cases: the Steubenville, Ohio H.S. gang rape.

2013, STEUBENVILLE, OHIO

- Two high school football players were found guilty of raping a 16-year-old girl in a case that drew national attention, principally because social media revealed the utter depravity of the crime.
- There is no better example of dehumanization

2013, STEUBENVILLE, OHIO

- The 16 year old victim was not a human being
- The only thing that defined her was secondary sexual characteristics of her body
- She was treated strictly as a sexual object – a sexual play toy
- She could just as well have been a life-size silicone rubber doll
- China & Japan – large industry in “love dolls”

2013, STEUBENVILLE, OHIO

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BUT “LOVE DOLLS” ARE INANIMATE OBJECTS:

- The 16 year old girl was drugged to unconsciousness, dragged naked from party to party, and raped repeatedly at the different parties.
- What degree of callous indifference and crass insensitivity is called upon to commit such a crime?
- She was a human being, not a silicone doll.

These same attitudes even find expression in the courtroom, and by high profile people and professionals.

Harvey Weinstein [Film Producer]: 13 women accused Weinstein of sexual harassment. Three of the women accused him of Rape. He was arrested on May 25th in New York and charged with Rape in the first degree, Rape in the third degree, and Criminal Sex with Another in the first degree.

Weinstein’s accusers stated that he hated the word ”no” and when confronted would threaten to derail the women’s careers.

James Franco [Actor; Golden Globe Award Winner]: Five women accused Franco of egregious acts of sexual misconduct.

Matt Lauer [NBC Today Show: Co-host]: Four women identified themselves as victims of sexual harassment by Lauer.

NBC reported that in Lauer’s 20 years with the company this was their first complaint about his behavior; however, within 48 hours of the accusations, Lauer was fired.

Larry Nassar [Physician]: 256 individual's accused the former USA Gymnastics national team doctor of sexual misconduct.

February 5th, 2018 Nassar was convicted of three counts of Criminal Sexual Assault in the first degree and sentenced to serve 40 to 125 years in prison.

July 18th, 2018 More than 140 survivors of Nassar's sexual abuse joined hands on stage to be honored with the Arthur Ashe Award for Courage at the ESPYs.

AND MANY OTHERS HAVE BEEN ACCUSED…

- **Jerry Sandusky [Pennsylvania State University College Football Coach]**
- **Marshall Faulk [Running Back – NFL]**
- **Ike Taylor [Cornerback NFL]**
- **Heath Evans [Full Back- NFL]**
- **Mario Batali [Chef, Writer, Media Personal]**
- **Charlie Rose [CBS This Morning: Co-host]**

- **Russell Simmons [Record Producer]**
- **Louis CK [Stand-up comedian]**
- **Steven Seagal [Film Producer]**
- **Dustin Hoffman [Actor/Director]**
- **Kevin Spacey [Actor]**
- **Bill Cosby [Actor]**

Judge Archie Simonson,
Madison, WI, 1977

Stated in his ruling that a 15 year old boy who raped a girl in a high school stairwell was reacting normally to relaxed cultural attitudes about sex and the recent fashion of more revealing clothing for women.

CA Court of Appeals (Blake, 1977)

Reversed the conviction of a man who raped a female hitchhiker, stating that a woman who enters the car of a stranger must expect sexual advances.

Los Angeles Times

Reported that a 1996 study by the American Journal of Obstetrics and Gynecology estimated that 32,101 pregnancies result from rape each year - accounting for roughly 5% of the victims (age range 12 to 45).

A simple exercise for you:

Images of this man – the victim of a robbery – are presented in court by the defendant's defense counsel:

DEFENSE COUNSEL ARGUES TO THE JURY:

- My client is charged with robbing this man.
- "Said robbery was alleged to have taken place at 1:15am on Slaughter St. in a run down neighborhood, basically a slum. What was the victim of this alleged robbery doing in that neighborhood, at that time, dressed in a 3-piece Herringbone suit?"

"I appeal to the best instinct of this jury to find my client innocent, because this man was asking to be robbed!"

CONGRESS PASSED VIOLENCE AGAINST WOMEN ACT IN 1994.

- In 2012, House of Representatives voted, for the first time in VAWA's history, NOT to re-authorize VAWA
- Critics of VAWA called the act: "unprecedented, unnecessary, and dangerous, noting that "Under VAWA, men effectively lose their constitutional rights"

MEN LOSE THEIR CONSTITUTIONAL RIGHTS?

- VAWA is **NOT** about men's "constitutional rights"
- It is about protecting women from sexually abusive men!

LESSONS LEARNED & REIFIED:

- Fathers, step-fathers, and adoptive fathers are the primary role models for demonstrating the basic tenets of "manhood" for their sons. They do so by their own behavior, in the way they treat their spouse, in how they define their role as husband and father, by the "rules" they lay down, and the "advice" and guidance they give to their sons.
- Youngsters connect with like-minded friends / peers as early as grammar school and on into high school – peers / friends reify / reinforce what was heard / learned at home.

LESSONS LEARNED & REIFIED:

- They go on to college where they gravitate toward peer groups that once again reinforce the same beliefs, attitudes and expectations of women and of their role in relationships with women.
- They follow social media, preferred news outlets and shock jocks, all part of a climate that reinforces powerful messages, some of which belittle and demean women, and objectify women as nothing more than sexual objects for men's use and pleasure.

THIS IS WHAT HAS BEEN REFERRED TO AS "RAPE CULTURE".

- Messages coming from the highest level of politicians – U.S. Representatives & U.S. Senators, as well as sitting judges, shock jocks, TV hosts & commentators.
- A constant reaffirmation by a society that frequently condones rape, tolerates rape, and excuses rape by demeaning & belittling women.

MULTIMEDIA RESOURCES

Program Videos

VIDEOS BY MODULE

BLACK denotes starrsa project produced video

BOLD videos are strongly recommended and denote a key video

** DOUBLE STAR indicates that it is highly recommended

GREEN denotes a public video

MODULE 2

SESSION 1

Student discussion session with Dr. Abrams: What is sexual assault?

Student discussion session with Dr. Abrams: Sexual assault statistics Part I (recommended for male victims)

Student discussion session with Dr. Abrams: Sexual assault statistics Part II

Student discussion session with Dr. Abrams: Sexual assault statistics Part III

Student discussion session with Dr. Abrams: Male victims and stigma (recommended for male victims)

http://endrapeoncampus.org/eroc-blog/2016/5/26/sexual-assault-on-college-campuses-what-we-can-do-motion-graphic

SESSION 2

STARRSA Locker Room Video

Student discussion session with Dr. Abrams: Consent Part I (also can use in Module 8)

Student discussion session with Dr. Abrams: Consent Part II (also can use in Module 8)

Student discussion session with Dr. Abrams: Consent Part III (also can use in Module 8, or Module 4)

Student discussion session with Dr. Abrams: Consent Part IV (also can use in Module 8)

Segment from The Hunting Ground (Something to the effect: "You mean if a girl says no and we have sex, it is rape?") or an alternative video clip with a similar message, such as the TedTalk: Sex Needs a New Metaphor – Here's One (See Resources).

SESSION 3

Student discussion session with Dr. Abrams: Legal Definitions of sexual assault

****Student discussion session with Dr. Abrams: Legal Definitions of consent**

Student discussion session with Dr. Abrams: Sexual assault and the law

****Student discussion session with Dr. Abrams: Sexual assault convictions**

WastedSex.com segment title: "Is this really a sex offense"

MODULE 3

SESSION 1

Student discussion session with Dr. Abrams: Social influences of sexual behavior

****Student discussion session with Dr. Abrams: Gender roles Part I**

Student discussion session with Dr. Abrams: Gender roles Part II

Student discussion session with Dr. Abrams: Sex and the Media Part I

****Student discussion session with Dr. Abrams: Sex and the Media Part II**

Student discussion session with Dr. Abrams: Assumptions based on stereotypes (can also use in Module 4)

SESSION 2

Student discussion session with Dr. Abrams: Culture and Sex

Student discussion session with Dr. Abrams: Factors related to campus sexual assault Part I

Student discussion session with Dr. Abrams: Factors related to campus sexual assault Part II

Student discussion session with Dr. Abrams: Attitudes Part II – Multiple partners (can also be used in Module 4)

SESSION 3

****Student discussion session with Dr. Abrams: Pressure to have sex**

Student discussion session with Dr. Abrams: Group dynamics and sexual assault Part I (can also use in Module 4)

****Student discussion session with Dr. Abrams: Group dynamics and sexual assault Part II (can also use in Module 4)**

Student discussion session with Dr. Abrams: Athletics, fraternities and sexual assault

MODULE 4

SESSION 1

***Student discussion session with Dr. Abrams: Attitudes and behaviors that objectify women**

Student discussion session with Dr. Abrams: Attitudes part I

Student discussion session with Dr. Abrams: Attitudes part II – multiple partners (can also be used in Module 3)

****Student discussion session with Dr. Abrams: Attitudes and sexual aggression**

Student discussion session with Dr. Abrams: Attitudes that support rape

Student discussion session with Dr. Abrams: Assumptions based on stereotypes (can also use in Module 3)

Student discussion session with Dr. Abrams: Environmental factors related to campus sexual assault (can also be used in Session 4)

SESSION 2

****Student discussion session with Dr. Abrams: Pornography Part I and II**

SESSION 3

Student discussion session with Dr. Abrams: Group think and deindividuation

Student discussion session with Dr. Abrams: College Parties Part I

Student discussion session with Dr. Abrams: College Parties Part II

Student discussion session with Dr. Abrams: College Parties Part III

WastedSex.com – Bystander video

SESSION 4

Student discussion session with Dr. Abrams: Environmental factors related to campus sexual assault (can also be used in Session 1)

****Student discussion session with Dr. Abrams: Dangerous situations (Can also use with Module 7)**

Tea and Consent: https://www.youtube.com/watch?v=oQbei5JGiT8

SESSION 5

Student discussion session with Dr. Abrams: Consent Part III (also can use in Module 8, or Module 2)

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part I

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part II

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part III

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part IV

****Student discussion session with Dr. Abrams: Alcohol and consent (also can be used in Module 8)**

Student discussion session with Dr. Abrams: The red cup phenomenon

***Student discussion session with Dr. Abrams: Alcohol, peers, and campus sexual assault**

WastedSex.com – Alcohol and Rape Video

MODULE 5

SESSION 1

Student discussion session with Dr. Abrams: Hypermasculinity

STARRSA Locker Room video (can also use in session 2)

Tony Porter: A Call to Men Ted Talk: http://www.ted.com/talks/tony_porter_a_call_to_men?language=en

Male athletes against violence: https://www.youtube.com/watch?v=-I7UAtd2h88

Cadets against violence: www.youtube.com/watch?v=VYzy6gsCqnE

Jackson Katz video: https://www.youtube.com/watch?v=ElJxUVJ8blw

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SESSION 2

Student discussion session with Dr. Abrams: Healthy Masculinity

****Student discussion session with Dr. Abrams: Accountability (can also be used in Module 9)**

Have the client listen to a couple of the TED talks on healthy masculinity; they are superb. We want to emphasize the importance of one Ted Talk in particular on "the man box" about masculinity and hostile masculinity; it is excellent, and should be considered a must:

http://www.ted.com/talks/tony_porter_a_call_to_men?language=en

https://changefromwithin.org/2013/11/21/please-be-that-guy-7-men-who-are-transforming-masculinity/ -- 7 men who are transforming masculinity -- Darnell Moore, Fivel Rothberg, Kai M. Green, Emiliano Diaz de Leon, Jackson Katz [It's a men's issue – below], Jeff Perera, Carlos Andres Gomez,

https://www.youtube.com/watch?v=LBdnjqEoiXA -- "Unmasking masculinity" – Ryan McKelley

https://www.youtube.com/watch?v=umKKrbmdHFM -- "The Mask of Masculinity" - Wade Davis

https://www.youtube.com/watch?v=jVI1Xutc_Ws -- "Be a Man" - Joe Ehrmann

https://www.ted.com/talks/zimchallenge?language=en -- "The Demise of Guys?" – Philip Zimbardo

Play List – 5 talks on How Masculinity is Evolving: https://www.ted.com/playlists/404/how_masculinity_is_evolving

Michael Kimmel: Why Gender Equality is good for everyone – men included

Tony Porter: A Call to Men

Colin Stokes: How movies teach manhood

Jackson Katz: Violence against women – it's a men's issue

Elizabeth Nyamayaro – An invitation to men who want a better world for women

Male athletes against violence: https://www.youtube.com/watch?v=-I7UAtd2h88

Cadets against violence: www.youtube.com/watch?v=VYzy6gsCqnE

Jackson Katz video: https://www.youtube.com/watch?v=ElJxUVJ8blw

MODULE 6

SESSION 1 & 2

STARRSA Victim Perspective video

Student discussion session with Dr. Abrams: Facts about sexual assault Part I

****Student discussion session with Dr. Abrams: Facts about sexual assault Part II**

Student discussion session with Dr. Abrams: Reporting sexual assault

****Student discussion session with Dr. Abrams: Impact of sexual assault**

Student discussion session with Dr. Abrams: Consequences of sexual assault

Student discussion session with Dr. Abrams: Who is impacted by sexual assault?

****Student discussion session with Dr. Abrams: Victim Blaming**

****Student discussion session with Dr. Abrams: Consequences of reporting sexual assault Part I and Part II (can use either one).**

Have a student client watch the following videos from WastedSex.com and discuss their reaction and the impact to these victim/survivors:

Morgan extended video

Michelle

Until it Happens to you by Lady Gaga **https://www.youtube.com/watch?v=ZmWBrN7QV6Y**

MODULE 7

SESSION 1

****Student discussion session with Dr. Abrams: Bystanders Part I and II**

Student discussion session with Dr. Abrams: Preventing and reducing campus sexual assault

****Student discussion session with Dr. Abrams: Dangerous situations (Can also use with Module 4)**

Student discussion session with Dr. Abrams: Stereotypes about perpetrators of sexual misconduct

MODULE 8

SESSION 1

Student discussion session with Dr. Abrams: Expectations in intimate relationships Part I

Student discussion session with Dr. Abrams: Expectations in intimate relationships Part II

Student discussion session with Dr. Abrams: The Dating Game

SESSION 2

Student discussion session with Dr. Abrams: Relationship stereotypes

SESSION 3

Student discussion session with Dr. Abrams: Communication Part I

****Student discussion session with Dr. Abrams: Communication Part II**

SESSION 4

STARRSA College Student Group Discussion video

Student discussion session with Dr. Abrams: TITLE IX

SESSION 5

****Student discussion session with Dr. Abrams: Confirming consent**

Student discussion session with Dr. Abrams: Sexual satisfaction

Student discussion session with Dr. Abrams: Consent Part I (also can use in Module 2)

Student discussion session with Dr. Abrams: Consent Part II (also can use in Module 2)

Student discussion session with Dr. Abrams: Consent Part III (also can use in Module 2)

****Student discussion session with Dr. Abrams: Consent Part IV (also can use in Module 2)**

Student discussion session with Dr. Abrams: Alcohol and consent (can also be used in Module 4)

MODULE 9

SESSION 1

****Student discussion session with Dr. Abrams: Accountability (can also be used in Module 5)**

WastedSex.com – Male Perspective

SESSION 2

****Student discussion session with Dr. Abrams: Supporting victims of sexual assault**

****Student discussion session with Dr. Abrams: Prevention of sexual assault on college campuses**

Student discussion session with Dr. Abrams: The power of peer engagement

STARRSA Returning to Campus Video

VIDEO DETAILS BY MODULE

STUDENT DISCUSSION SESSIONS WITH DR. ABRAMS & STARRSA VIDEO SKITS

MODULE 2

SESSION 1

Student discussion session with Dr. Abrams: What is sexual assault?

Intro: The line between seduction and sexual assault may seem blurry at times. Let's listen as this group of students talk about what they think sexual assault is.

Outro: Sexual assault is any type of contact sexual behavior that occurs without the consent of the other person. Simply-stated, unwanted sexual behavior. Dr. Abrams mentioned different types of sexual assault. What are some other examples?

Key areas:

- The definition of sexual assault is discussed.
- The difference between contact sexual assaults versus non-contact sexual assaults is discussed.

Student discussion session with Dr. Abrams: Sexual assault statistics Part I

Intro: The perception that only women are victims of sexual assault is false. Men are victims of sexual assault too. In this clip the group talks about men experiencing sexual assault, and as you'll see, not everyone sees it the same way.

Outro: As we just learned from Dr. Abrams, roughly 1 in 6 men are victims of sexual assault. While the group

members discuss the ways in which men will spin a sexual assault as “a bad experience” or “I took one for the team,” the truth remains the same for men as it does for women: any type of unwanted sexual contact is sexual assault.

Key areas:

- The idea that men are not victims of sexual assault is false.
- One out of six men will be the victim of sexual assault in their lifetime.
- The role of alcohol intoxication: men have difficulty or an inability to properly consent to sex when inebriated, and it is considered sexual assault.
- The male's perception of sexual assault differs from that of female victims of sexual assault, and there is a lower rate of report.

Student discussion session with Dr. Abrams: Sexual assault statistics Part II

Intro: Sexual assault happens everywhere and impacts people of all sexes and gender identities. It is nearly impossible for individuals to not know someone who has been a victim of, or perpetrator of, sexual assault or unwanted sexual behavior.

Outro: While numerous sexual assault intervention programs currently exist, there has been no measurable decrease in perpetration rates. Why do you think the statistics are still so high? According to these statistics, if you consider four women that you know, one of them would have experienced some type of unwanted sexual assault.

Key areas:

- Sexual assault is wide spread and exists in all areas of life.
- It is “impossible” for an individual to not know someone that is the victim or perpetrator of sexual assault.
- The issue of sexual assault affects both men and women, and it is falsely presumed to be solely a women's issue.
- One out of four females are the victim of sexual assault, one out of six males are the victims of sexual assault.
- There has been no decrease in the overall rate of sexual assault on college campuses for the past twenty years, regardless of reduction efforts.

Student discussion session with Dr. Abrams: Sexual assault statistics Part III

Intro: Statistically speaking, it is more common for males to sexually assault females. In this respect, many individuals commonly reference males as being the perpetrators and women as the victims. However, males can sexually assault males, women can sexually assault women, and women can sexually assault men. Let's see what the group thinks about this.

Outro: Anyone, males or females, can be a victim or perpetrator of sexual assault. Sexual assault is not strictly limited to females solely being the victims and males being the perpetrators

Key areas:

- Statistically more often than not it is a male sexually assaulting a female; however, men can sexually assault men, women can sexually assault women, and women can sexually assault men.
- Sexual assault victims or perpetrators are not solely limited to men or women, it occurs for both genders/sexes.

Student discussion session with Dr. Abrams: Male victims and stigma

Intro: There's a lot of stigma around males who have been sexually assaulted. Let's listen to the group discuss why this might occur.

Outro: There are some cases in which males are victimized by females—for example, we sometimes hear news stories where female teachers being sexual active with their male students. Sometimes men and boys have been victimized by other men. However, many men are hesitant to disclose the assault. How do you think concepts of masculinity or beliefs about sexual assault victimization impact the ability and willingness of male survivors to come forward, and to be believed?

Key areas:

- The majority of the time that males are sexually abused, they are younger than the perpetrator.
- Most male victims of sexual assault were assaulted by male perpetrators.
- The group discussed the difficulty of societal stigmas about homosexuality and homophobia, and how this may contribute to the reduced likelihood of male victims reporting sexual assaults.
- In a circumstance when the perpetrator is a female and the victim is an intoxicated male that may not have wanted to engage in sexual activities with the female, it is often interpreted by the victim as a "bad experience" and not as a sexual assault.
- The group discussed the instances of male students being assaulted by an older female teacher, and the male students viewing this as a positive sexual experience rather than a sexual assault.

SESSION 2

The Locker Room Video (can also use in module 5, session 2)

Intro: What follows is a scene in a locker room involving three student athletes preparing for soccer practice while discussing a party they had been to the previous evening.

Outro: This video raises a number of issues, including the minimization and justification of sexual assault and placing blame on the victim. As he tried to justify his behavior to the teammate that was challenging him, he

placed more and more blame on the victim: her choice to come to the party, her choice to drink, her choice to dress the way she did.

If someone came up to you on the street, pulled a knife and demanded your wallet, what would you think if the criminal blamed you for being robbed....that somehow of the stylish clothes you wear or your decision to walk down a street in the "bad" part of town at the wrong time of the day? What would you think if the guy's defense was that you were asking to be robbed? You'd probably think it was ridiculously inexcusable.
THIS is no different. You did not consent to being robbed at knifepoint. Assault and battery is assault and battery. In one case, the criminal is stealing money. In the other case, the criminal is stealing sex.
The key issue in this video is consent. Consent is not an abstract concept. Consent simply means agreement, as in, "I agree to have sex with you." It means giving permission, as in, "I permit it." Simply stated, it means, "it's ok with me." In every way you say it, it means that the other person has clearly and freely agreed to have sex. Consent should not be assumed. If there is any question, assume that consent has not been given. Make sure that you get a clear "Yes".

In this sketch, the victim passed out, either from too much alcohol or as a result of some form of drug. In either case, she obviously was incapable of providing consent. There was no ambiguity there. Being conscious is a requirement to giving consent. So...if she was unconscious, it is a sexual assault. Period. Forced or unwanted sex equals rape. Stealing sex after you have rendered a woman unconscious is rape.

In many situations, consent may be much more ambiguous than in the sketch you just watched. Drugs and alcohol can impair thinking, perception and judgement, including one's ability to perceive social cues. It also can impact one's ability to communicate clearly. If you're hammered, blacked out, inebriated, or whatever other term you prefer, your thinking and judgement are impaired. At what point someone's thinking and judgment becomes impaired varies depending on many factors. Body weight, food consumed (or lack thereof) prior to drinking, alcohol potency (proof), quantity consumed, as well as mixing other illicit drugs with alcohol, can all influence how intoxicated the individual becomes.

There are times that people deliberately use drugs and alcohol as weapons to intoxicate potential sexual partners. Besides the use of Date Rape Drugs (i.e. Rohypnol, GHB, Ketamine), even the possession of them is illegal under Federal law and in many states.

The most important factors to consider when determining consent are verbal and nonverbal communication. Through either words or behavior, your partner must express willingness to have sex. If there is any ambiguity in your mind, check with your partner and affirm consent. If it is unclear in YOUR mind, it is likely to be unclear in your partner's mind. And if your partner is not comfortable communicating his or her feelings about sex, you can pose this question: "Would you prefer not to have sex?" If they're feeling uncomfortable, that answer only requires a nod of the head. The bottom line is, if there is any ambiguity, the answer is no!

Key areas:

- If someone is unconscious due to alcohol intoxication, they are not able to give consent.

- Consent requires both people to be awake and both people need to want to have sex.
- How a woman is dressed has nothing to do with her consenting to have sex (she is not "asking for it.").
- People's perceptions of rape often change when it happens to someone close to them.

Student discussion session with Dr. Abrams: Consent Part I (also can use in Module 2)

Intro: What exactly is consent? How do you know if someone has given consent, or is even capable of giving consent? The group discusses the nuances of consent in this clip and situations when it's ambiguous.

Outro: Some may think consent isn't always clear, however a clear "yes" is necessary. "Yes" means yes, "no" means no, and "maybe" can mean no as well. A person can say "no" at any time, even if they had previously said "yes." Often sex, especially when it's the first time with a particular person, IS a big deal. How do you know for sure that the person is consenting in the heat of the moment?

Key areas:

- The issue and definition of consent are discussed.
- How does consent interact with the law in regard to sexual behaviors? Consent means something specific when talking about the legal system.
- The group discussed the role of alcohol and the effect it may have on an individual's ability to consent.
- The presumption of consent is that an individual has the ability to consent to sexual behaviors until proven otherwise (or under certain circumstances).
- The group discussed the circumstances/conditions where consent to sexual behaviors may not be available. How do you determine the ability for someone to give consent?
- During ambiguous situations, consent should not be assumed.
- The "state of mind" of an individual matters in their ability to give consent (i.e., alcohol or drug use may impair the individual to properly give consent).
- Consenting to sexual behaviors can be complex: "maybe", mixed messages, or anything other than a clear "yes" should be interpreted as a "no".
- Consent has to be in the affirmative, if there is any uncertainty, then it is a "no".
- The concept and phrase "blue balls" and how it is uncomfortable, but it is not fatal and the misconception that men have about this phenomenon.
- The "blue balls" and entitlement/ the right to "finish" or ejaculate.

Student discussion session with Dr. Abrams: Consent Part II (also can use in Module 8)

Intro: In this clip, the group was talking about consent, but what about when drinking is involved? Or in situations when people have already had sex in the past? Does consent work the same way? Let's hear what the group thinks.

Outro: Whether it's sex for the first time or not, consent is always something that must be obtained, and as

Carlos said, “consent is something that should be given every time.” How do you have that discussion? Is “discussion” realistic in every situation? In other words, do people really have “a discussion” beforehand or at the moment? How do you shift to “discussing” consent when you're in the middle of undressing each other? If someone appears to be allowing herself to be undressed, does that imply that she is consenting? Can consent really occur in “the heat of the moment”? In what ways is consent between two people that are drinking at a party complicated? What about expectations of sex in a long-term relationship or marriage? How does consent work in relationships and marriages?

Key areas:

- Someone has to have the affirmative ability to consent to sexual activity. If there is any type of reason that significantly interferes with a person's ability (i.e., intoxication or drug use) it should be assumed that consent for sexual activity CANNOT be given.
- In the instance of a male or female being too intoxicated, there is a distinct difference between other observers “taking care of” him/her or “taking advantage of” him/her.
- There is a misconception that due to previous sexual engagement with a partner, an individual does not have to achieve consent for future sexual behaviors. Consent should be given every time sexual activity may occur.
- Every intimate sexual activity is like a “contract” where both individuals agree to engage in the sexual activity. Discussion of how to execute this “contract.” Consent should be obtained each time two people engage in a sexual act.
- Being in a relationship with someone does not guarantee that sex will occur every night. Consent should never be assumed, even if two people are married or in a long-term relationship.
- In relationships, there should be the established dialogue between partners for when sexual activities will occur. Both individuals in the relationship should know their partner well enough to make sure that they are “into it” or ask if they want to engage in sexual activity, there should be vocalization of “yes” or “no” when consenting to any sexual activity.

Student discussion session with Dr. Abrams: Consent Part III (also can use in Module 8)

Intro: Consent can be revoked at any time during a sexual encounter, but if partners already have difficulty understanding consent, this becomes complicated. The men in this group discuss some concerns they have about the process of obtaining consent, raising some important questions, including issues and concerns about the legal system.

Outro: This clip covered the complexity of obtaining consent in the moment as a sexual encounter unfolds. Dr. Abrams posed the question about how to ensure that you have consent as sexual activity progresses, in the moment. Throughout a sexual encounter, there are verbal and nonverbal ways in which both partners reaffirm their consent. Sometimes, though, partners are unable to, or are uncomfortable with, speaking up if they do not like something, if something is painful, or if they simply want to stop. Checking in becomes important because of these instances. Intoxication may lessen a partner's awareness and lead to an impaired ability to check in. What are some signs that might indicate consent – or lack of consent? What signs indicate discomfort? What are some things you can do in the moment to confirm consent?

Key areas:

- Asking a partner during a sexual act if they consent from moving from "first base" to "second base" and so forth. In other words, how can consent be achieved in each variation of sexual behaviors when engaging in an intimate act, and how may it be clear that both partners want to progress to another part of the sexual act.
- Communicating with your partner that you do not want to go further with the sexual activity is essential.
- Communication of consent to progress into another part of the sexual act may occur by verbally asking them to stop, or physically pushing away from your partner.
- The issue with reading the "signs" of whether your partner wants to engage in a certain sexual activity. This can occur for both males and females, especially if intoxicated, and these signs may become difficult to interpret.

Student discussion session with Dr. Abrams: Consent Part IV (also can use in Module 8)

Intro: Our notions of what "consent" means may be influenced by the media (i.e. TV and social media). The media rarely, if ever, portrays communication between a couple that reflects consent. Either consent is assumed, or the encounter obviously is unwanted and constitutes some form of sexual assault.

Outro: Among many other aspects of how we view ourselves, media clearly can influence our ideas of what masculinity "looks like" or what it means to be "masculine." Thinking about how we develop our beliefs and what factors shape our ideas and attitudes about gender roles, masculinity, and sex is important to understanding ourselves. Not surprisingly, it is also critically important in developing healthy relationships with partners. In what ways do you think that the media influences your notions of what appropriate and inappropriate sexual behavior is? Do you feel that you have beliefs or attitudes about gender roles, masculinity and sex that you might want to change?

Key areas:

- How has social media, tv shows, or movies portray the "bad guy" that all women "want" and how does this effects men's perception of engaging in a conquest for sexual activity with a female?
- The social constructs of "chivalry" or being a "good guy" are discussed and how getting the attention of females or consent for sexual activity may be misperceived. In other words, men may perceive women wanting the "bad guy" and when engaging in sexual behaviors men may behavior this way, instead of achieving consent.
- The misconception and expectations of the media and how women and men are supposed to dress or behave towards one another is discussed.
- The group discusses the definition of and the pressures for men to be influenced by these expectations.
- The development of male maturity and the ability to learn from the proper definitions of masculinity or proper role models.
- The group discusses the importance of males learning to express emotions and solve problems without physical violence.

SESSION 3

Student discussion session with Dr. Abrams: Legal Definitions of sexual assault

Intro: It's possible that in some cases, guys may think they've received consent when they actually haven't? In this clip, the group discusses instances that guys do not think are sexual assault that are according to many state laws.

Outro: It is important to understand basically what the law says about sexual assault and rape in the state that you are in. For example, if a woman feared for her safety, whether she expressed that fear or not, it is considered sexually assault in some states. Understanding what the relevant law says is not a big undertaking; it could take all of 10 minutes on the Internet. Understanding the law is only part of it. Understanding your partner is the most important part!! And understanding your partner includes understanding that alcohol and drugs can impair your judgement and your partner's judgment. Impaired judgment includes impaired ability to consent to sexual activity.

Key areas:

- Knowing what the law is surrounding sexual assault should be common knowledge for both men and women.
- There is a possibility that men may be ignorant of whether proper consent has been achieved with a partner.
- Sexual assault and the complexities of the law are discussed.
- If there is even the absence of threats to the victim or force, it may still be a sexual assault if affirmative consent is not achieved.
- Determining the intentions of both people engaging in the sexual act is vital and should occur in order to avoid any legal issues or the potential for sexual assault to occur.
- Alcohol intoxication and "reading the signs" incorrectly is part of the legality of sexual behaviors and important in order to avoid sexual assault from occurring.

Student discussion session with Dr. Abrams: Legal Definitions of consent

Intro: The laws surrounding consent for sexual activity may be different from state to state, and student codes of conduct may define it differently at different colleges. Let's hear more about consent and the law.

Outro: The laws surrounding consent are extremely complex, because consent itself can be complex. Hearing a "yes" before any activity has occurred can be one way of showing consent. This is called "affirmative consent." But affirmative consent, posing the question "would you like to have sex with me?" can easily feel stilted, awkward, unnatural, like asking "you want to go get a cup of coffee?" So what are other more comfortable, relaxed ways of asking? Often physical contact precedes any "discussion." So any some well before you round 3rd base and head for home, you must simply say something like "are you comfortable with this?" What are some warning signs that you DON'T have consent to keep going in a sexual encounter?

Key areas:

- The group discussed the change over time of how the law defines consent.
- The group discussed the steps that a female victim may take after a sexual assault has occurred (showering, reporting, getting a "rape kit," and her thoughts/feelings).
- Rape Shield Laws are mentioned, as well as the weak efficacy of these laws for the victim.
- When a sexual assault occurs and both parties are intoxicated, it may be difficult to determine who may or may not report. In the instance of two males or two females engaging in sexual assault, the perpetrator of sexual assault is typically the individual that is inserting something into the other individual.
- Forcible Compulsion is when someone agrees to have sex, for the fear that if they do not comply or have sex they will be hurt.
- The law is fluid and there may not be clear cut parameters for when consent has or has not been achieved.
- Making sure and confirming that consent is achieved with a "yes," is important.

Student discussion session with Dr. Abrams: Sexual assault and the law

Intro: Statues involving sexual assault and how it is defined vary state to state. Let's hear more about sexual assault and the law.

Outro: It is important to be aware of your school's Student Code of Conduct definitions of sexual misconduct. Sometimes, sexual behavior does not rise to the level of being a crime, but it still is a conduct violation.

Key areas:

- Each state has a different definition of sexual assault.
- The perpetrator of sexual assault is typically the individual that is inserting something into the other individual.

Student discussion session with Dr. Abrams: Sexual assault convictions

Intro: In this clip, the group expresses the belief that guilt can only be proven by a guilty verdict in court. But what happens when the truth is more complicated?

Outro: Very few accusations of sexual assault are false. Often, sexual assault is not reported and even when it is, the amount of evidence needed to win a guilty verdict is very difficult to reach. There is a difference between being guilty of a crime and being convicted of it. Because of this, it can be difficult to judge whether someone accused of sexual assault should be held responsible socially, especially when the person being accused and the person doing the accusing are part of a common group of friends. The "truth" may never be known outside of the people who were involved in the incident. What do you think about the idea that survivors should be believed automatically, by default?

Key areas:

- Sexual assaults may not be reported, but in some instances (e.g., by word of mouth) the sexual assault

may come to be known by others; what are the perceptions of these perpetrators, and how does this affect his/her social life with peers?
- Sexual assaults may not be proven in court or the perpetrator may not be convicted. Most sexual assault may not be reported or further meet the burden of proof in a court of law.
- It is exceedingly rare that false reports of sexual assault occur.
- One false report may skew the publics' perception, endangering the legitimate instances of sexual assault.
- Often men overestimate false reports of sexual assault when hearing about an incident, but this perception may change if it is a member of their family, friend, or loved one.

MODULE 3

SESSION 1

Student discussion session with Dr. Abrams: Social influences of sexual behavior

Intro: Social pressure for both men and women can create complex situations for relationships, dating, and sex. The group talks about their thoughts on social pressure on men and how this can influence their actions.

Outro: Think of what you see on TV, in the media, in music videos, in the movies. Do you relate to what the group had to say about social pressure and expectations of men? Do you agree? Do you agree with what Dr. Abrams' said about society sending messages that permit women, but not men to ask for help? What are some messages that you commonly see about gender, sex and expectations? Are these realistic? How can they be harmful to people?

Key areas:
- The group discusses male socialization and the needed conquest for sexual success with women.
- Issues of self-esteem and insecurity for both males and females and the differences in each are discussed.
- The group discusses hypermasculinity and the need for males to fulfill the male pressures to provide for and be dominant in a relationship with a female.
- Social intelligence of females versus males is discussed.

Student discussion session with Dr. Abrams: Gender roles Part I

Intro: In this segment, Dr. Abrams asks this group of college males what their thoughts are about prostitution and quid pro quos in dating relationships. If a man pays for dinner, does the woman owe him sexual favors? In this clip the group discusses expectations in dating and gender roles.

Outro: Do you agree with the statement that men pay for sex one way or another? Are you are paying for sex by taking a woman out? What if it's "Dutch"? Does that mean no sex? A "quid pro quo," or expecting a favor in return something, is clearly an unhealthy basis for an interaction between men and women, unless the "contract" is stated and agreed upon in advance (e.g., "You pay for dinner and the movie, and we'll go back to my place"). What typically happens, however, is that there is NO stated "contract." It is assumed by one party and not the other. Healthy relationships are ones where both parties want to be together and not based on tallies or owing favors.

Key areas:

- The group discusses men paying for sexual activities with a woman, and how it impacts a man's "ego."
- The group discusses male self-esteem and the interaction between paying for sex versus taking it (in the instance of sexual assault).

Student discussion session with Dr. Abrams: Gender roles Part II

Intro: This next clip covers important topics about social roles and expectations. This includes expectations that men and women have about each other's roles in sexual, romantic, and family relationships, media influences, hypermasculinity, the iconic "tough guy" role devoid of emotion and weakness, and the relationship between emotional expression and gender. The group discussed the importance of identifying and understanding one's own emotions and how this may conflict with traditional ideas of masculinity.

Outro: It takes maturity, strength, and courage for us to think beyond stereotypical or negative messages about men and women's relationships that are provided by experiences ranging from our upbringing to mainstream media advertising, movies, and pornography. Ideas that women exist only as sexual objects and that men can take what they want from women without taking into consideration women's sexual and emotional needs leads to markedly unhealthy relationships, a rape culture, and an unhealthy fiction about gender roles. Furthermore, subscribing to extreme views of social and gender roles can lead to unhealthy consequences. By rethinking our definition of masculinity to include valuing self and others, providing emotional support, and accepting one's vulnerability is part of true strength.

Dr. Abrams suggests that strength involves self-awareness and the vulnerability to be emotionally honest with those who you trust and who make you feel safe. Emotions are a part of the human experience and can help us understand ourselves, and the world. How we express and how we manage our emotions can affect our behavior and our health. Men are often taught to believe that strength means hiding or ignoring their emotions. Men further come to learn that if there is to be an emotion expressed, the only acceptable emotion for a man is anger. When we ignore our emotions, when do not learn how to manage them or use them to our benefit, we run the risk of harm – to ourselves or to others. Consider the ways in which emotions can be useful, such as helping to motivate us to accomplish a difficult task to or develop meaningful relationships with others.
One way men can fix and achieve a healthy working relationship with their emotion life is by rethinking their ideas about masculinity. Men receive messages, even as young boys, that they have to be "bad boys" or "the

man of the house" so they can take care of their families and gain women's approval. However, no person can maintain this role forever. Suppressing emotions, pretending not to have feelings, or ignoring your emotions can lead to very serious physical and emotional problems, problems that erupt in unintended and unhealthy ways. It's much smarter and safer to work on finding a balance between being emotional and feeling secure. When we ignore our emotions, when do not learn how to manage them or use them to our benefit, we run the risk of harm – to ourselves or to others.

Consider the ways in which emotions can be useful, such as helping to motivate us to accomplish a difficult task to or develop meaningful relationships with others. Think about the following questions: What messages did you receive from friends, family, and the media about what it means to be a man? What about messages and rules about expressing your feelings, and your vulnerabilities? How do your rules about expressing emotions fit in with your ideas about being a man?

Dr. Abrams suggested that "toughness," rather than being walled off from feelings, is actually connected to claiming and understanding our feelings. Does this make sense to you? What concerns do you think men have about expressing their emotions? What concerns do you have about expressing emotions? What are the qualities of healthy masculinity? Can you think of any men in your life who you admire for having qualities of healthy masculinity?

What beliefs about gender roles have you seen among your friends, family, and the media? How do you define masculinity, femininity? Where do your conceptions of masculinity and femininity come from? What, if any, of these conceptions might be inaccurate?

Key areas:

- The group discusses how unrealistic and fictionalized pornography creates a sexually learned behavior for men that may be reenacted in their sexual activities.
- The concept of males perceiving females as sexual objects, that solely exist to please men sexually, and that females should be subservient to males is discussed, as well as the concept of male dominance and their role in relationships to be stronger and to "provide" (e.g., shelter and protection) for the females.
- The group discusses the need for males to acknowledge vulnerability and express their emotions. By doing this, they would be "providing" for females. Males need to redefine masculinity and develop self-awareness and confidence to "provide" and "handle business", but also be able to understand emotions and express them.
- There is a societal expectation for men to never show their emotions. How a man is raised may have a very important impact on a man's perception of their masculinity.

Student discussion session with Dr. Abrams: Sex and the Media Part I

Intro: Social pressure can come from friends, but it can also come from social media, movies, and TV shows.

Outro: Popular media can paint a picture for men and women about how they should act and who they should

be. What are your thoughts about how men and women should interact? Are they consistent with stereotypic media messages, or different?

Key areas:

- Sexual assault may be exacerbated by the way social media portrays sex and women.
- A discussion of how social media influences human perception and how individuals view themselves. This may affect how men and women interact or "prey" on each other.

Student discussion session with Dr. Abrams: Sex and the Media Part II

Intro: Much has been discussed (and studied) about the effects of sexual and violent media on individual behavior and on society at large. Children and teenagers have easy access to virtually everything that crosses the Internet, including a vast range of violent depictions as well as sexually abusive and sexually aggressive depictions. How, if at all, has the Internet – and media in general - impacted our views of sex and sexual aggression? That is what the group will discuss today.

Outro: Overexposure to sexually violent media can be unhealthy, especially for those that are at higher risk to engage in unwanted sex. Violent media can desensitize us to violence and normalize violence. Sexually-violent media not only normalizes sexual aggression, but it objectifies and dehumanizes women. Do you have a sense of how sexual and violent media depictions have affected you? Your attitudes about sexuality? Your attitudes about women?

- **Key areas:**
- The group discussed the degree of inference that media (e.g., pornography or social media) affects the male perception of women.
- Music videos, movies, or TV shows glamorize the "scantily clad women" and communicate the message that degrading women is an acceptable way to have both non-sexual and sexual relationships.
- The exposure to this type of hyper-sexualized and violent media contributes to how children or teenagers may form opinions on women and sex on an unconscious level.

Student discussion session with Dr. Abrams: Assumptions based on stereotypes (can also use in Module 4)

Intro: Sometimes males will judge women based on their physical appearance and dress. What about women? Do women judge other women based on their clothing? Here we here a group of college women talk about these topics.

Outro: What assumptions are made about a woman who is scantily dressed? Is this normal, valid? How might this be accurate, inaccurate and lead to problems? Do you agree with the student who said that there is a basis for women thinking that some clothing choices are poor? What assumptions do you make about a woman

based on her clothing, makeup, etc.? Do you ever act differently based on how women are dressed?

Key areas:

How does male or female clothing play a role in sexual assault, if any?
Assumptions of women and men dressed in particular clothing that are false.
Women may also form their beliefs about how a woman is dressed in a negative way.

SESSION 2

Student discussion session with Dr. Abrams: Culture and Sex

Intro: In this clip we hear from students about how culture impacts beliefs and attitudes about gender, sex and relationships. Does culture contribute to a double standard for men and women when it comes to monogamy?

Outro: There are numerous factors impacting one's sexual behavior, including parental values, religious and ethnic norms and values, and peer and community influence. For example, we heard one student say that monogamy among Dominicans is not highly valued as compared to other cultures. Is monogamy the norm? Who is expected to remain monogamous – only women? Both men and women? Do you think it is possible to have healthy sexual relationships without monogamy? Think about your own cultural upbringing. What are some attitudes and beliefs that your culture (background, ethnicity and religion) has about men, women, sex and relationships? Do you agree with all of these ideas? Have your values or attitudes changed over time?

Key areas:

- The group discussed infidelity in relationships and cultural acceptance or encouragement from relatives or peers for men versus women.
- Discussion of monogamy and expectations based on cultural values and personal morals.
- There is a double standard of men and women having multiple partners; men are viewed in a positive light for having multiple partners, while women are viewed in a negative way for having multiple partners.
- Certain religions and cultures may perpetuate a man having multiple spouses or partners which makes it difficult to determine how this may interact with sexual activity and culture solely.
- The group discussed the misconceptions of females being perceived as "asking for it" if they have a past of promiscuous behavior.

Student discussion session with Dr. Abrams: Factors related to campus sexual assault Part I

Intro: Incidence rates of college sexual assault appear to be increasing, or are they? Is the media now just reporting on it, whereas in the past they paid no attention to it? What are the factors contributing to these rates and what can we do to change it? Let's see what the group thinks.

Outro: There are many reasons why sexual assault continues in our society. What do you think are some

factors that explain sexual assault on college campuses?

Key areas:

- One out of every four women will be sexually assaulted at some point during their lifetime.
- One out of every six men will be sexually assaulted at some point during their lifetime.

Student discussion session with Dr. Abrams: Factors related to campus sexual assault Part II

Intro: Is it okay to take sex from someone regardless of whether or not they wanted to "give" it? Is unwanted sex no different from unwanted theft of your property (as in "stealing" sex)? If unwanted sex is equitable with theft or stealing and a majority of individuals honestly believe that this is not okay, how come sexual assault incidence rates are so high? This is what the group will discuss today.

Outro: Many believe that the party scene existing on college campuses is one of the primary factors contributing to these rising rates of sexual assault. More parties might lead to more opportunities for sexual assaults to occur. Do we need to get rid of parties to prevent sexual assault, or is there a way to make drinking spaces safer? What do you think?

Key areas:

- Is the common male opinion that it is acceptable for men to "take" sex when it is not offered?
- If common conception is "no" and that taking sex is wrong, is there a definitive way to determine why sexual assault occurs?
- In which situations is it likely that sexual assault will occur? According to the group's opinion, parties on a college campus would perpetuate this occurrence.

Student discussion session with Dr. Abrams: Attitudes II – Multiple Partners (can also be used in Module 4)

Intro: In this next clip, the group discusses situations in which multiple men are having sex with one woman, whether at different times or all at the same time. Although this discussion is uncomfortable, it raises some important questions and perspectives.

Outro: Do you agree with the statement that they are "just pieces of body?" Although the topic may be uncomfortable for the group to discuss, or for yourself, it's important to think about the attitudes and perspectives men have when there are multiple guys having sex with the same woman. Is she being treated like a human being, or just a sex object? Did she consent? Is she just a "piece of meat"? How may these attitudes contribute a rape culture and lead to sexual assault?

Key areas:

- The group discusses "hooking up" with a friend's previous partner, whether it is a girlfriend or a previous

sexual partner.

- There is a stigma of a woman being "easy" or "passed around" because she has engaged in sexual acts, or is in a committed relationship, with multiple men of the same peer group.
- When considering the instances of multiple men with one woman (i.e., five guys and one girl), men may miss the concept that they too are having sex with a man, not solely the woman.
- In instances where a woman is not being treated as a human being, but rather just a "piece of meat" or a "hole" for male sexual arousal, she is not consenting, especially if she is unconscious.
- Using alcohol or drugs to completely inhibit or eliminate the woman's ability to consent occurs quite often, and is used to incapacitate the woman for a sexual assault involving multiple men.

SESSION 3

Student discussion session with Dr. Abrams: Pressure to have sex

Intro: Men, especially college age guys, may feel social pressure to have lots of sex partners – or just lots of one time sexual "conquests," lots of friends with one special benefit. The group talks about their own personal experiences with the pressure to have sex with a number of women.

Outro: Does the number of women you slept with make you more of a man? Is a man's "masculinity" based on the number of women he has sex with? The number of notches in his belt? Is sex the currency for popularity among men? Do you feel like you relate to this pressure? How does it affect how men interact with women? Do you agree that men feel the need to appear like they've got everything figured out instead of admitting that there are things they don't know?

Key areas:

- College campuses often promote the mentality that having sex and males bragging about sexual conquests is necessary.
- Often on college campuses, there is an exaggeration by men about the number of sexual experiences or partners that they have had.
- When men are perceived as more confident than shy, there is the misconception that they will have more sexual opportunities.
- Sex is the "currency" that determines value for men.

Student discussion session with Dr. Abrams: Group dynamics and sexual assault Part I (can also use in Module 4)

Intro: Athletes and fraternities have the highest rates of sexual assault on college campuses. What do they have in common? The group discusses group dynamics and how it relates to campus sexual assault.

Outro: Group dynamics and peer influence can create environments where things like misogyny, objectifying

women, and using alcohol to lower women's resistance to sex become acceptable. Group mentality can have a strong influence on how someone can act, but in the end each individual has to be accountable for his or her own behavior. Do you agree with what the group said about conformity and compliance?

Key areas:

- The group discusses conformity amongst groups of people and its influence on attitudes and beliefs.
- There are times where people do things in a group that they would never do if they were not in the group.
- Concept of group think – people who identify with a group tend to take on the morals of the group.
- It is not simply belonging to a fraternity or being an athlete – Dr. Abrams explains the power of group dynamics and peer influence.
- Even if a person engages in a behavior as part of a group, it is important that they have individual accountability. Being in a group is not an excuse.
- Like alcohol, being in a group is not an excuse to sexually assault someone. They are both influential factors to consider when discussing ways to reduce incidents sexual assault.

Student discussion session with Dr. Abrams: Group dynamics and sexual assault Part II (can also use in Module 4)

Intro: Group mentality can influence a great deal of how individuals act, but in this next clip the question is brought up about what an individual can do within a group.

Outro: Being part of a group can be good, and having a brotherhood can be enriching. However, if the group mentality becomes harmful it can be very hard for an individual to go against it. The ranking structure and peer pressured environment can lead individuals to doing things that they would not otherwise do. Each and every one of us must weigh our own values against the group values and make a personal decision. At the end of the day, we own our behavior, not the group's behavior. At the end of the day, we are each accountable for our own actions. Do you agree with the comments that it is hard to get people to stand up when they are part of a group? If you agree, what makes it hard?
If we can get men to become responsible for themselves, while also having the courage to stand up for others who are at risk for being hurt or victimized, sexual assault could potentially be prevented. This is unlikely to happen on a large scale, however, so simply reframing the way men view these risky situations - from helping the victim to helping prevent their "brothers" from receiving a jail sentence - could have an effect on reducing sexual assault.

Key areas:

- Discussion of how group mentality plays a role in sexual experiences and how males view this.
- Group values versus personal values.
- How to stand up when facing a group whose values differ from your own.

Student discussion session with Dr. Abrams: Athletics, fraternities and sexual assault

Intro: There have been a lot of news reports about athletics, fraternities, and sexual assault, almost always in the context of partying. Today, the group is discussing this issue.

Outro: How do you think campus culture of partying contributes to the larger problem of sexual assault, and even going so far as institutional cover up cases of sexual assault perpetrated in the context of parties, often hosted by fraternities?

Key areas:

- The group discusses the culture of college campuses, and how certain groups (fraternities or others) may contribute to the ideas of sexual assault in either positive or negative ways.

MODULE 4

SESSION 1

Student discussion session with Dr. Abrams: Attitudes and behaviors that objectify women

Intro: Attitudes towards women can say a lot about how a man feels he can treat women, for example, with cat calling. The group goes further into these perceptions and how they can play out with sexual assault.

Outro: Do you agree with the explanations that the group provided for why guys cat call and engage in behavior that objectifies women? When we objectify someone, they literally become an "object," not a person. When someone objectifies another person, it dehumanizes them. Attitudes that objectify women are dehumanizing. What are some examples of attitudes that objectify women?

Key areas:

- The group discusses the socialization of men and the strong influence of sex.
- Men are taught that their success is going to be defined by how many females he sleeps with.
- Social desirability - some males continue to behave in ways that prove unsuccessful (e.g., cat calling) to impress or show off in front of peers.
- Behaviors that are dehumanizing towards women contribute to misogynistic attitudes.
- A woman's outfit should not be predictive of whether she will be sexually assaulted.

Student discussion session with Dr. Abrams: Attitudes part I

Intro: It's a common misconception that when women dress a certain way, "they're asking for it." However,

it's rare to hear someone say the way a man is dressed implies he wants sex. Let's see what the group thinks about how people dress, when the roles are reversed, and what it signifies.

Outro: The way someone dresses can never determine whether or not they are looking for sex. Although being well dressed or dressing provocatively may be meant to attract a partner, for both males and females, clothing never justifies sexual assault! What if you were wearing a three-piece dress suit? Would it justify your being robbed?

Key areas:

- Clothing of women versus men in sexual assaults: what are the common misconceptions and what are the issues in believing them?
- Dressing in a promiscuous way does not warrant or permit sexual assault to occur. If a woman is wearing something tight-fitting or low cut it is not an invitation for sex.

Student discussion session with Dr. Abrams: Attitudes II – Multiple partners can also be used in Module 4)

Intro: In this next clip, the group discusses situations in which multiple men are having sex with one woman, whether at different times or all at the same time. Although this discussion is uncomfortable, it raises some important questions and perspectives.

Outro: Do you agree with the statement that they are "just pieces of body?" Although the topic may be uncomfortable for the group to discuss, or for yourself, it's important to think about the attitudes and perspectives men have when there are multiple guys having sex with the same woman. Is she being treated like a human being, or just a sex object? Did she consent? Is she just a "piece of meat"? How may these attitudes contribute a rape culture and lead to sexual assault?

Key areas:

- The group discusses "hooking up" with a friend's previous partner, whether it is a girlfriend or a previous sexual partner.
- There is a stigma of a woman being "easy" or "passed around" because she has sexual intimacy or is in a committed relationship with multiple men of the same peer group.
- When considering the instances of multiple men with one woman (i.e., five guys and one girl), men may miss the concept that they too are having sex with a man, not solely the woman.
- In instances where a woman is not being treated as a human being, but rather just a "piece of meat" or a "hole" for their sexual arousal, she is not consenting, especially if she is unconscious.
- Using alcohol or drugs to completely inhibit or eliminate the woman's ability to consent occurs quite often, and is used to incapacitate the woman for a sexual assault involving multiple men.

Student discussion session with Dr. Abrams: Attitudes and sexual aggression

Intro: What are the attitudes that people have that contribute to sexually aggressive behavior and sexual assault? The group discusses their own personal experience with social pressure to have sex with lots of women, and their views on how women also pressure men.

Outro: Wanting to have sex is normal. Often, women come on to men, just as much as men come on to women. However, when having sex becomes so important that there is a disregard for the other person, that person's boundaries, comfort, and pleasure, it is harmful and can easily lead to sexual assault. This is no longer mutual sex. This has become a conquest. The goal, at virtually any cost, is to end the evening with intercourse. The group discussed peer pressure and peer expectations about sex and obtaining sex. Does this sound at all familiar?

Key areas:

- Normalizing sexual activities and behaviors, but not normalizing sexual assault or rape.
- How to make sure that the individuals engaging in sexual activity are not being pushed into something they do not want.
- Sexual aggression should not be used to get sex without consent.
- Peer pressuring and expectations in how men or women should achieve sex with another person.

Student discussion session with Dr. Abrams: Attitudes that support rape

Intro: In this clip, Dr. Abrams talks to the group about ways in which society can have "rape supportive attitudes" and discusses the importance of being aware of those attitudes.

Outro: There are situations in our day-to-day lives that normalize rape supportive attitudes, such as clubs that offer free drinks for women but not men. Can you think of any other situations that make people vulnerable to sexual assault?

Key areas:

- Discussion of some rape supportive attitudes that occur in society on a day to day basis.
- Discussion of situations or instances that may promote these rape supportive attitudes and increase the likelihood of sexual assault.

Student discussion session with Dr. Abrams: Assumptions based on stereotypes (can also use in Module 3)

Intro: Sometimes males will judge women based on their physical appearance and dress. What about women? Do women judge other women based on their clothing? Here we here a group of college women talk about these topics.

Outro: What assumptions are made about a woman who is scantily dressed? Is this normal, valid? How might

this be accurate, inaccurate and lead to problems? Do you agree with the student who said that there is a basis for women thinking that some clothing choices are poor? What assumptions do you make about a woman based on her clothing, makeup, etc.? Do you ever act differently based on how women are dressed?

Key areas:

- How does male or female clothing play a role in sexual assault, if any?
- Assumptions of women and men dressed in particular clothing that are false.
- Women may also form their beliefs about how a woman is dressed in a negative way.

Student discussion session with Dr. Abrams: Environmental factors related to campus sexual assault (can also be used in Session 4)

Intro: In this next clip, the group discusses various factors related to campus sexual assault. Specifically, the impact of the change in environment which includes increased freedom, increased opportunities for social interactions, peer pressure, social expectations, and less parental oversight in the role of sexual misconduct.

Outro: Consider the different factors raised by the group. Which factors discussed do you think are relevant? Have any of these factors impacted your behavior? How might these factors be related and coalesce to result in risky situations?

Key areas:

- At college, students are more "free" and not under the oversight of their parents. If students live on campus, there is more opportunity for parties and going out.
- There is a double standard regarding men and women. There is peer pressure for men to sleep with as many women as possible (to be seen as more masculine), and sometimes if men cannot get with women, they resort to sexual assault. However, a woman sleeping with a lot of men is viewed more negatively.
- Parental attitudes (i.e., how a person was raised), sexual education, and peer groups can also impact if a person will engage in sexually assaultive behavior. Dr. Abrams noted that upbringing is not the end all for who will engage in sexually assaultive behaviors.
- College is a time to question everything and learn. It is a time when people have a time to find their own path. It takes individual strength to stay on the right path when peer pressure is strong.

SESSION 2

Student discussion session with Dr. Abrams: Pornography Part I

Intro: In this clip, the group talks about pornography and the expectations these fictional mediums set for our own sexual experiences.

Outro: Pornography is readily accessible today and often is the first exposure people have to sex. This can

create highly unrealistic expectations on what sex is supposed to be like, what role men play, and what role women play. Typically, in pornography a man's gratification is the primary goal and the primary focus of the camera, contributing to the obvious conclusion that men's sexual gratification is far more important than women's sexual gratification. What are some of the common stereotypes that you have seen in pornography? How does it differ from real sexual experiences that you have had?

Key areas:

- Usually, men are exposed to pornography at an earlier age than women.
- The unrealistic expectations of pornography and how it can influence perceptions of sexual activities is discussed.
- Pornography can contribute to the sexual aggression of males or the belief that females will act the same as the females portrayed in pornography.
- The stereotypes depicted in pornography can be observed (and assimilated) by the viewer.

Student discussion session with Dr. Abrams: Pornography II

Intro: Pornography frequently portrays a dehumanizing view of women, reducing their role to assisting men achieve sexual gratification. Our "hook up culture" may also dehumanize sexual partners, because the sole objective is "using" your partner to achieve sexual gratification. Let's see what the group has to say.

Outro: People tend to have strong convictions about pornography, hook ups, and what it means to value another person beyond what that person can do for you. Whether someone routinely engages in hook ups or "one night stands," or short-term "friendships with benefits," or long term monogamous relationships, it's important to never forget that your partner is a human being, not a sexual object.

Key areas:

- Discussion of ways that pornography perpetuates a dehumanizing view of women.
- In general, the messages that pornography sends about women helping men achieve pleasure or orgasm may contribute to attitudes about sex and women.
- Pornography may be the precursor for the male's opinion of sex and feeling that he has to engage in sexual activities, relationships, and "hook-ups".

SESSION 3

Student discussion session with Dr. Abrams: Group think and deindividuation

Intro: In this clip, the group of women give their insight on sexual assault and the "mob mentality" that can persuade both men and women to do things they might not normally do. Let's hear what they have to say.

Outro: College can be a difficult transition as new students try to make new friends and fit in. Although being

part of a group can be good for personal growth and self-esteem, it can lead to a group mentality or "group think" that accepts unquestioningly and condones things that frequently would not be accepted by you or other individuals when not in the group. This includes things like cat calling, unwanted sexual touching and groping, sexual pressure, and other forms of negative sexuality that escalate to sexual aggression. What are some common behaviors that you could imagine yourself doing to impress your friends?

Key areas:

- Everyone is influenced by their peer group because they want to fit in and there is social pressure to fit in.
- Sexual assault is often the result of a series of steps that start with subtle acts, like cat calls.

Student discussion session with Dr. Abrams: College Parties Part I

Intro: Transitioning to college and young adult life brings a lot of new stressors to a person's life. Partying is a coping mechanism for many, but what happens when it gets out of hand? Let's listen in.

Outro: The excitement and freedom of being in college come with lots of new responsibilities, as well as new sources of stress. Alcohol and other drugs are used to relieve stress but can also contribute to an environment that is conducive to sexual assault. When under the influence of alcohol or drugs, we often do not notice or pay attention to troubling behavior, or we may just not want to step in and ruin the party atmosphere. But it is everyone's responsibility at the party to watch for warning signs and intervene when someone crosses a line. How do you deal with an environment where the majority of people are, in varying degrees, intoxicated and where intervening may not be positively received? One sober person cannot be relied on to protect everyone else. What can be done to create more accountability at parties or other similar social events?

Key areas:

- College is a time of excitement and freedom, but also a time of new responsibilities.
- Stress of college life can lead people to want to party as a way to relax.
- How do you stay responsible at a party where everyone (males and females) are drinking and partying? Often, the responsible person is the one who is not drinking (such as the designated driver).

Student discussion session with Dr. Abrams: College Parties Part II

Intro: Here, the group describes how a party environment full of intoxicated students can make consent much more difficult to navigate. Whose responsibility is it to step in when consent is unclear?

Outro: Alcohol increases the vulnerability of the woman, can blur the lines of consent, and increase the likelihood of unwanted sex. When someone is intoxicated, even a "yes" can't always be taken as consent, especially when there is unfamiliarity with a partner's preferences and limits.

There is disagreement about who should be responsible for preventing sexual assault in situations where

everyone is intoxicated; some place the blame wholly on women and teach men that they are only responsible for taking what they want. Do you agree the idea that the responsibility to avoid unwanted sex should fall primarily on women? What are some things that everyone can engage in to be safe at parties where alcohol is present?

Key areas:

- Alcohol can impact a person's ability to consent; alcohol can make a situation unclear and make it difficult to determine if someone is actually capable of consenting.
- There are different views presented throughout the discussion. On one side, females are often taught to protect themselves at party and males are not really taught how to act at parties (such as not looking at women differently based on what they are wearing), but on the other side, women should take accountability for their actions and take precautions.

Student discussion session with Dr. Abrams: College Parties Part III

Intro: It goes without saying that most college students like to party. Sexual assault often occurs in the context of a party environment. What is it about a party environment? What checks might be put in place to guard against sexual assault at parties? Let's listen in on the discussion.

Outro: Do you agree with Dr. Abrams comments? Do you agree with the groups' comments? Both men and women are responsible to look out for friends and to speak up when someone is acting inappropriately, but often, they don't. Usually they're waiting on someone else to be the first to speak up or to act. We are comfortable with discussing "designated drivers," but we don't talk about "designated partners" (who agree not to drink and to be observant). What are some potential consequences of being the one who steps in when a situation appears to be unsafe? What are some potential benefits? Is it realistic to expect others to intervene? Imagine being the guy in the real case example that Dr. Abrams provided.

Key areas:

- Alcohol, the party scene, and sexual assault.
- Dr. Abrams explains the complexity of the issue surrounding possible ways to prevent sexual assault from occurring at college parties.
- Getting extremely intoxicated may be poor decision-making, but does not warrant being sexually assaulted.
- Insight from a female perspective (e.g., it's the friend's responsibility to make sure that someone else does not get intoxicated and taken advantage of).
- The responsibility of males to step in if they notice a situation that may result in sexual assault.
- Bystanders need to intervene if they notice someone in a situation that may result in a sexual assault.

SESSION 4

Student discussion session with Dr. Abrams: Environmental factors related to campus sexual assault

(can also be used in Session 1)

Intro: In this next clip the group discusses various factors related to campus sexual assault. Specifically, the impact of the change in environment which includes increased freedom, increased opportunities for social interactions, peer pressure, social expectations, and less parental oversight in the role of sexual misconduct.

Outro: Consider the different factors raised by the group. Which factors discussed do you think are relevant? Have any of these factors impacted your behavior? How might these factors be related and coalesce to result in risky situations?

Key areas:

- At college, students are more "free" and not under the oversight of their parents. If students live on campus, there is more opportunity for parties and going out.
- There is a double standard regarding men and women. There is peer pressure for men to sleep with as many women as possible (to be seen as more masculine), and sometimes if men cannot get with women, they resort to sexual assault. However, a woman sleeping with a lot of men is viewed more negatively.
- Parental attitudes (i.e., how a person was raised), sexual education, and peer groups can also impact if a person will engage in sexually assaultive behavior. Dr. Abrams noted that upbringing is not the end all for who will engage in sexually assaultive behaviors.
- College is a time to question everything and learn. It is a time when people have a time to find their own path. It takes individual strength to stay on the right path when peer pressure is strong.

SESSION 5

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part I

Intro: Is alcohol to blame for sexual assault? The group discusses what alcohol's role is in sexual assault.

Outro: Alcohol is not an excuse. Alcohol alone isn't a cause of sexual assault. Alcohol is a disinhibitor that impacts our judgment and our perception. Although alcohol is often a factor in sexual assault, each individual is responsible for their own actions, and the acts committed under the influence of alcohol are not excused just because someone was drinking.

Key areas:

- The group discussed the prevalence of alcohol on college campuses.
- Eliminating alcohol from college parties will not completely rid college parties of sexual assault. Alcohol may disinhibit an individual but there are underlying issues concerning that person's morality (i.e., the thoughts and desires that are usually inhibited).
- If an individual is intoxicated during the perpetration of a sexual assault, the justice system does not simply excuse the incident. Alcohol is not a singular factor for sexual misconduct.

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part II

Intro: Alcohol can impede a person's judgment, and bad decisions can often be chalked up to being drunk. Dr. Abrams and the group discuss their thoughts on alcohol and its role in sexual assault.

Outro: Regardless of alcohol, people are ultimately accountable and responsible for their own actions. Alcohol does not remove the accountability of an individual who commits sexual assault.

Key areas:

- Alcohol can make a person aggressive, or impair a person's judgment, causing them to act in ways that they would not normally act.
- Regardless of alcohol, people are ultimately accountable and responsible for their actions.

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part III

Intro: Does intoxication prevent one from providing consent to have sex? Let's hear some thoughts on this.

Outro: What IS the legal definition of intoxication? How can we determine if someone is so intoxicated they can't give consent? How would you approach a situation where you interested in hooking up with a woman that is intoxicated?

Key areas:

- If someone is intoxicated, they cannot consent to have sex.
- Intoxication varies from person to person.

Student discussion session with Dr. Abrams: Alcohol and sexual assault, Part IV

Intro: It's easy for college students to get alcohol, even if they're underage. There's a social expectation to drink, and indeed even to binge drink. However, for some students, alcohol is a powerful disinhibitor for engaging in unwanted sex and sexual assault.

Outro: Getting hammered or blitzed at parties is not just acceptable but the norm for many college students. However, peer pressure to binge drink or drink to the point of intoxication is associated with sexual assault for some students. When you're drunk, you have "license" to do things that you want to do but would most likely not do if you weren't wasted. Moreover, it is very hard to read cues from another person who is trying to communicate that they don't want sex. In some states, a person can't consent to sex when they're intoxicated, and it's automatically considered sexual assault. From you own experience, how do your interactions with others change when you're drinking?

Key areas:

- Social drinking is big on college campuses, and college is the first time many students have easy access to alcohol.
- Peers can pressure you to act certain ways, especially at parties where there is alcohol and other substances around.

Student discussion session with Dr. Abrams: Alcohol and consent (also can be used in Module 8)

Intro: Intoxication by alcohol or other drugs impact judgement and perception. Alcohol can decrease a person's understanding of consent and help pave the way to unwanted sex, but education can serve as a buffer to prevent negative consequences. Here, the group is given an important lesson.

Outro: A "maybe" or a "probably" or a shrug or a nod or even a smile does not constitute a "yes." A "yes" can't be assumed, especially when one or both partners are intoxicated. Communication is an important part of sex but some factors, like alcohol intoxication, decrease the likelihood of it being clear. If there is any doubt about whether a partner is willing or able to consent to sex, it's always better to stop or wait. What might be some other signs to stop? What are some nonverbal signs that a person isn't into it? Or simply that the person is incapable of protesting? What other factors indicate that a partner can't or doesn't consent?

Key areas:

- A person's ability to read nonverbal cues, and interpret intentions, becomes impaired when they are intoxicated.

Student discussion session with Dr. Abrams: The red cup phenomenon

Intro: Today the group discusses the "red cup." If you are not holding a "red cup" at a party, then you are not cool. How does this peer pressure to drink at parties contribute toward sexual assault? This is what we'll be discussing in today's video.

Outro: The problem with red cups is that it is difficult to identify which cup belongs to you. All too frequently, drugs (e.g., date rape drugs) are slipped into someone's drink, and that someone becomes a victim of rape. What can we do to address the red cup problem, permit everyone to drink who wants to drink, and keep everyone safe?

Key areas:

- Alcohol consumption is frequently pushed on people, especially young adults and those involved in the party scene.
- The group discusses how using open cups can lead to potentially dangerous situations.

Student discussion session with Dr. Abrams: Alcohol, peers, and campus sexual assault

Intro: Do women know which guys to stay away from? How much to drink? Who they should associate with and who to avoid, especially when drinking? What is the relationship between alcohol, peers and sexual assault? These are the questions the group is tackling today.

Outro: There are many factors that can contribute to a sexual assault, but none of them are a cause for sexual assault. How do you think this impacts what we should be doing to prevent assaults from happening? Although it is always important to choose friends that we feel compatible with, friends that match our values and our interests, but how often do you "adopt" as friends people that are NOT really compatible with you but that you "pretend" to like because they are cool (like the 2013 Echosmith single "Cool Kids"), part of the in-crowd, in a word – popular? Unfortunately, many of these cool kids are bullies with hugely inflated egos.

Key areas:

- It is important to try and surround yourself with the people who will have your back and look out for you, especially if you are drinking.

MODULE 5

SESSION 1

The Locker Room video (Can also use in Module 2, Session 2)

Intro: What follows is a scene in a locker room involving three student athletes preparing for soccer practice while discussing a party they had been to the previous evening.

Outro: This video raises a number of issues, including the minimization and justification of sexual assault and placing blame on the victim. As he tried to justify his behavior to the teammate that was challenging him, he placed more and more blame on the victim: her choice to come to the party, her choice to drink, her choice to dress the way she did.

If someone came up to you on the street, pulled a knife and demanded your wallet, what would you think if the criminal blamed you for being robbed....that somehow of the stylish clothes you wear or your decision to walk down a street in the "bad" part of town at the wrong time of the day? What would you think if the guy's defense was that you were asking to be robbed? You'd probably think it was ridiculously inexcusable. THIS is no different. You did not consent to being robbed at knifepoint. Assault and battery is assault and battery. In one case, the criminal is stealing money. In the other case, the criminal is stealing sex.

The key issue in this video is consent. Consent is not an abstract concept. Consent simply means agreement, as in, "I agree to have sex with you." It means giving permission, as in, "I permit it." Simply stated, it means, "it's ok with me." In every way you say it, it means that the other person has clearly and freely agreed to have sex. Consent should not be assumed. If there is any question, assume that consent has not been given. Make sure that you get a clear "Yes".

In this sketch, the victim passed out, either from too much alcohol or as a result of some form of drug. In either case, she obviously was incapable of providing consent. There was no ambiguity there. Being conscious is a requirement to giving consent. So...if she was unconscious, it is a sexual assault. Period. Forced or unwanted sex equals rape. Stealing sex after you have rendered a woman unconscious is rape.

In many situations, consent may be much more ambiguous than in the sketch you just watched. Drugs and alcohol can impair thinking, perception and judgement, including one's ability to perceive social cues. It also can impact one's ability to communicate clearly. If you're hammered, blacked out, inebriated, or whatever other term you prefer, your thinking and judgement are impaired. At what point someone's thinking and judgment becomes impaired varies depending on many factors. Body weight, food consumed (or lack thereof) prior to drinking, alcohol potency (proof), quantity consumed, as well as mixing other illicit drugs with alcohol, can all influence how intoxicated the individual becomes.

There are times that people deliberately use drugs and alcohol as weapons to intoxicate potential sexual partners. Besides the use of Date Rape Drugs (i.e. Rohypnol, GHB, Ketamine), even the possession of them is illegal under Federal law and in many states.

The most important factors to consider when determining consent are verbal and nonverbal communication. Through either words or behavior, your partner must express willingness to have sex. If there is any ambiguity in your mind, check with your partner and affirm consent. If it is unclear in YOUR mind, it is likely to be unclear in your partner's mind. And if your partner is not comfortable communicating his or her feelings about sex, you can pose this question: "Would you prefer not to have sex?" If they're feeling uncomfortable, that answer only requires a nod of the head. The bottom line is, if there is any ambiguity, the answer is no!

Key areas:

- If someone is unconscious due to alcohol intoxication, they are not able to give consent.
- Consent requires both people to be awake and both people need to want to have sex.
- How a woman is dressed has nothing to do with her consenting to have sex (she is not "asking for it.").
- People's perceptions of rape often change when it happens to someone close to them.

Student discussion session with Dr. Abrams: Hypermasculinity

Intro: Boys are often taught to "be a man," "toughen up," don't show emotions, don't be "weak," above all, never shed a tear. Today, the group is going to talk about "hypermasculinity."

Outro: Hypermasculinity and "compensatory narcissism" (compensating for not feeling "like a man," or feeling insecure about one's masculinity by coming off as super-masculine, building impressive muscles and conspicuously showing them off, etc.) can occur when men don't have healthy ways to deal with their insecurities. They try to look "tough" because they think that's what's expected of them. What women find attractive, however, rarely includes these displays of hypermasculinity. Traits that women find much more attractive include self-confidence, a sense of humor, intelligence, the ability to be an active listener and take the perspective of your partner. How do you think hypermasculinity plays out in relationships that you've seen on campus? How about yourself?

Key areas:

- Compensatory narcissism is overcompensated to look tough. In situations where you cannot really have a conversation (i.e., in a club), physical attractiveness can be important.
- Males, including athletes, may feel the need to go out and look tough to feel important if they are struggling elsewhere in their life.

SESSION 2

Student discussion session with Dr. Abrams: Healthy Masculinity

Intro: "Machismo," or macho, typically refers to men that present with an exaggerated presentation of power or strength and masculinity, always strong, dominant, and in control. Today, the group is discussing how masculinity and "machismo" shape men's self-concept.

Outro: What is healthy masculinity? Is it being domineering and controlling? Does it mean "strutting your stuff," showing off, preening around like peacock? How do you think men's sense of their masculinity plays a role in their sexual relationships?

Key areas:

- Machismo refers to the notion that men should feel dominant and in control all the time, which can lead to things like sexual conquests.
- This follows the concept of "if you are going to be dominant, you should take what you want."

MODULE 6

SESSION 1 & 2

Victim Perspective video

Intro: What follows is a scene from a survivor's perspective and experience. This short film includes staged sexual violence.

Outro: The effects of sexual assault last well beyond the sexual act. Survivors experience physical as well as emotional harm from sexual assault, and seeking help to deal with the experience is only the first step towards healing. Although someone who has nonconsensual sex may see it as just that: sex, it's not just sex to the person who never agreed to it, who never wanted it, and who never consented to it. In this video, Sarah was sexually assaulted after she unknowingly consumed a drug that caused her to lose consciousness after struggling to get away from the situation. She clearly did not consent. In other situations, however, sometimes those found responsible of misconduct don't believe that what happened was misconduct. "It was just a misunderstanding" or "It was really consensual." What for one person may seem like miscommunication or misunderstanding, for another person it can be deeply painful and long lasting. Unwanted sex is not like being arm-twisted or going to a movie you did never really wanted to see. If you never wanted the experience, it could make you feel ugly. No matter what you think may have happened, there is another human being involved that may think differently. What do you think Sarah felt when she regained consciousness? Why do you think she seemed anxious at the beginning of the video? How might those who have been sexually assaulted feel? What are the long-term term consequences that victims are likely to experience?

- **Key areas:**
- A victim can face many different consequences after an assault, such as emotional difficulties, academic difficulties, and social difficulties.
- Victims may also have health issues as a result, and may have to seek medical treatment after the assault.
- Victims often lose the support of their friends, especially if they do not tell them what occurred.
- Victims can display signs and symptoms of trauma, such as dissociation, flashbacks, and enhanced startle response, as well as hypervigilance.
- Victims often seek mental health treatment to help them deal with the trauma of being assaulted.

Student discussion session with Dr. Abrams: Facts about sexual assault Part I

Intro: Sexual assault is a painful, or at the very least uncomfortable, topic, so we distance ourselves by thinking that, "it could never happen to me, or the people that I love. In reality, of course, unwanted sex and

sexual assault happens with alarming frequency to people from all walks of life. No one is immune unless you live in a monastery.

Outro: What are the consequences of sexual assault for the victim, perpetrator, and society? What are some myths you think people believe about sexual assault? How do these myths impact their response to survivors?

Key areas:

- Often times, people try to believe that sexual assault is an issue that is further away than it actually is.
- Knowing someone who assaulted someone else, or knowing a victim of assault, personalizes the issue.

Student discussion session with Dr. Abrams: Facts about sexual assault Part II

Intro: Stranger rape is far less common than acquaintance rape / date rape. In other words, most rapes are not perpetrated by a stranger in a dark alley but with people who know each other. This can sometimes make it complicated for determining consent and whether an incident was indeed unwanted and hence sexual assault.

Outro: There is NO substitute for frank, open conversations about sexual wants, sexual needs, and sexual boundaries with every partner, every time. And, just because people have had sex before (i.e., they are not "virgins") does NOT mean that consent exists for another sexual encounter. Thinking about what the students in this video discussed, what are some situations you can think of where consent might be fuzzy? What are some nonverbal cues that a person does not want to have sex? What are some ways that people can have clearer communication about sex, especially in hook up situations where they may not know each other well to begin with?

Key areas:

- Acquaintance rape is much more common than stranger rape.
- Nuances in understand nonverbal and verbal interactions play a part in sexual assault. Adding alcohol into the mix can make it even more difficult to effectively interpret signals.

Student discussion session with Dr. Abrams: Reporting sexual assault

Intro: Reporting sexual assault is not always an easy choice for a survivor. They may doubt themselves, feel ashamed, or feel that they won't be believed. Sometimes survivors receive messages that they are in some way responsible, or to be blamed, for the assault. Today, the group is discussing how people react when someone says they have been sexually assaulted.

Outro: Reporting sexual assault takes courage, and yet many people who report a sexual assault are not only unsupported but may be blamed and feel stigmatized. The reality is that sexual assault is not falsely reported more than any other crime. There are messages ingrained in our society that someone who was sexually assaulted deserved it, asked for it, or is lying about it. Image what it would be like if you reported being

assaulted and were told you were lying or making up the whole thing. How would you feel if you were called a liar after reporting an assault? How would you feel if your friends shunned you or avoided you after you reported being assaulted?

Key areas:

- In addition to the legal and health consequences of a sexual assault, victims also sometimes have to deal with the social stress of their friends turning against them.

Student discussion session with Dr. Abrams: Impact of sexual assault

Intro: Being found responsible for sexual misconduct can bring up many emotions, including anger, guilt, sadness, and embarrassment. In addition, the incident impacts family and friends for both the survivor and person found responsible. Today, the group is discussing how sexual assault impacts different people.

Outro: The aftermath of dealing with sexual assault can go on for years, for everyone involved. The impact doesn't end after the assault. What emotions came up for you? How has the experience impacted your relationships with family and friends? What do you think it's been like for the victim?

Key areas:

- The perpetrator may also experience negative consequences after a sexual assault (e.g., prison is not a good environment despite glamorization on TV).
- The school/institution may also be negatively impacted by the assault.

Student discussion session with Dr. Abrams: Consequences of sexual assault

Intro: In this clip, the group talks about all the subsequent consequences of sexual assault for victims.

Outro: From the perspective of the victim, think about each stage of seeking help and reporting a sexual assault as Dr. Abrams has outlined. For each stage, make a list of what the victim might be feeling and thinking and the struggles that they might encounter at each stage.

Key areas:

- Risk of pregnancy and STI's are a major potential consequence of sexual assault.
- A victim may also have to deal with prosecutors asking them difficult questions if they decide to report the assault.
- Victims also have to undergo a rape kit if they decide to go to the hospital, which can be invasive and even re-traumatizing.
- Other consequences for victims include mental health issues, such as PTSD and suicidality, as well as losing social support.

Student discussion session with Dr. Abrams: Who is impacted by sexual assault?

Intro: Who is impacted by sexual assault? It seems like an easy question, but the answer is not. Impact has a ripple effect. Let's hear more about this.

Outro: In this quick clip, Dr. Abrams provided a glimpse of the impact of sexual assault. A sexual assault not only impacts the individuals directly involved, but extends out to families, partners, loved ones, parents, siblings, friends, and even communities such as sports teams, fraternities, and the university. Everyone involved, directly and indirectly, in a sexual assault can be impacted in some way. How has this impacted you? How has this impacted your family and friends? How has this impacted your life?

Key areas:

- The consequences experienced by everyone (e.g., victim, perpetrator, system, families) are not often brought up in discussions about sexual assault.
- If these consequences were brought up more frequently, there might be more responsivity.

Student discussion session with Dr. Abrams: Victim Blaming

Intro: Sometimes when a sexual assault has occurred, people question whether the person reporting the assault is lying, or whether they simply regret it after the fact. In this clip, the group discusses victim blaming, and forcible compulsion.

Outro: As we just heard, fake reports of rape are very rare. Victims rarely have anything to "gain" by reporting sexual assault, and much to lose. Victims are often re-victimized by the criminal justice system – and even by society. Blaming the victim is just disowning responsibility for your behavior, displacing responsibility onto the victim. NON-consent includes coercing and / or pressuring the victim to have sex. It's still sexual assault. If someone came up to you on the street and "pressured" you to turn over your wallet, it would still be simple assault and theft. It sure as hell wouldn't mean that you "consented" to be relieved of your wallet. It would most likely mean that you were afraid of worse consequences if you didn't hand over your wallet.

Key areas:

- False reports of rape are very rare (2-5%). Rape is not falsely reported more than any other crime.
- Regret is not the same as sexual assault.
- Forcible compulsion is when a victim complies with a sexual act because they fear they might be hurt otherwise. Some states do not even require the victim to communicate they were afraid.
- Rape shield laws are laws that state that when prosecuting a rape, the past sexual behaviors and experiences of the victim cannot be brought up.
- Consent should be clearly in the affirmative – anything other than an explicit yes is a no.

Student discussion session with Dr. Abrams: Consequences of reporting sexual assault Part I

Intro: Many people believe that those who come forward with accusations of sexual assault are often lying in order to get fame, money, or revenge. In this clip, the group discusses why it takes courage to publicly call yourself a survivor of sexual assault and why false beliefs about reporting harm survivors.

Outro: Sexual assault is not falsely reported any more than other types of crime. It is categorically inaccurate to assert that victims are usually lying. Reporting sexual assault to police or administrators can have serious repercussions. Sexual assault is a life changing event with long term consequences for all parties involved. A survivor may lose friends, face shame, embarrassment, disbelief about the rape, have their reputation discredited, or be traumatized by the legal proceedings. Sexual assault is very serious and it takes bravery to come out as a survivor. By the very nature of sexual assault, it is highly invasive, and, as such, is often humiliating and demeaning.

Key areas:

- Sexual assault has a lower false report rate than any other crime.
- Sexual assault investigations can include a victim's peer group not supporting her, the male feeling like he did her a favor, the police might say she made the whole thing up, people on the college campus might work to make the whole thing go away, the victim might have to undergo a rape kit, and if it goes to trial, the attorney might try to blame the victim.
- The victim may need psychological help, experience symptoms of PTSD, or feel the need to transfer schools because she does not feel safe.
- If the assault goes public and is broadcasted in the media, university recruitment may be impact.
- Incarceration is also a potential impact for the perpetrator.

Student discussion session with Dr. Abrams: Consequences of reporting sexual assault Part II

Intro: Many survivors of sexual assault are reluctant to report what happened to them to the authorities because they are afraid of the consequences. Here, the group talks about what some of those consequences might be.

Outro: In the aftermath of an assault, those that have been sexually assaulted may feel afraid, ashamed, and embarrassed. Stronger emotions include feeling humiliated and "dirty" to the point that no bath or shower can remove the filth. They may worry about their personal safety and feel very uncomfortable sharing any space with the person who assaulted them. However, the idea of reporting the crime to authorities may be just as frightening and survivors may wish to avoid the traumatizing experience of a university cover-up, a rape kit, or a disbelieving district attorney. If the person who was sexually assaulted does come forward, they may be blamed and disbelieved by nearly everyone around them. Survivors often feel very alone after their assault. To some extent, this can be alleviated by creating supportive environments free of victim-blaming attitudes that only makes survivors' isolation worse. What are some victim-blaming statements or actions that you have seen toward people who have been sexual assaulted?

Key areas:

- Victims might not report because they are afraid that it might happen again. They also might be ashamed and embarrassed, especially if there is a chance they will see the perpetrator around campus.
- Victim blaming is a common occurrence (e.g., "she put herself in that situation," "she was dressed a certain way," "she was asking for it").

MODULE 7

SESSION 1

Student discussion session with Dr. Abrams: Bystanders Part I

Intro: If a guy stops another guy from coming on to a girl, is he "cockblocking"? Or keeping him from making a mistake? The group shares their thoughts about intervening between a guy and girl.

Outro: It's sometimes necessary for friends and bystanders to intervene in situations where a guy can be taking it too far with a girl without her consent. How can standing up in these situations start to change attitudes in a peer group? What kind of moral courage does it take to intervene on behalf of a potential victim? What are some reasons why people don't intervene?

Key areas:

- "Cockblocking" refers to when a guy gets in the way of another guy's pursuit of a female.
- It's not cockblocking when a friend stops another friend from taking it too far with a girl if she is not able to consent.

Student discussion session with Dr. Abrams: Bystanders Part II

Intro: Many sexual assaults happen during parties or other events where lots of people could have intervened before it was too late. Why doesn't anyone speak up? Let's examine some possible reasons.

Outro: In social situations, lots of peer pressure dictates expected, conforming behavior. Many people promise they would speak up if they saw warning signs of an assault, but in the moment they lack the courage to do so. In failing to intervene, they leave a friend to face potentially devastating consequences. They may also assume that the behavior is someone else's problem, or that someone else will take care of it. There are umpteen excuses for not intervening. And that is what they are – excuses. Men with healthy masculinity come to the aid of victims; they don't create victims. When no one acts, everyone is responsible for failing to act. What

are some tactics you think you might be able to use to intervene in a risky situation? How would you act if the woman in the risky situation was your girlfriend? Or your sister? Or your mother?

Key areas:

- It is important to "police" your friends and try to keep them from making poor decisions.
- Many men say that they would stand up if someone is being assaultive, but in reality, most people do not actually intervene.
- A lot of the work on prevention of sexual assault focuses on bystander intervention. However, the more people present in a situation results in a diffusion of responsibility, where no one speaks up because they believe someone else will.

Student discussion session with Dr. Abrams: Preventing and reducing campus sexual assault

Intro: This next clip considers ways to prevent and reduce campus sexual assault. Advocacy is a good start. Advocacy is a good way to increase awareness of sexual assault on campus, but is it enough?

Outro: In the end, advocacy is not enough. Programs and prevention strategies that teach students about consent and healthy sexuality are necessary. Intervention programs for victims and students responsible for sexual assaults are needed as well. Think about your own campus: What do you think would be helpful to reduce sexual assault? What kind of programs would most likely help?

Key areas:

- Beyond prevention, it is important to look to organizational leaders to help with prevention and teaching them good values.
- Beyond prevention, groups and support for victims is also important.
- The intentions and attitudes of the perpetrator also need to be addressed; it is not enough to give them a slap on a wrist. If they do not receive treatment, it could happen again.

Student discussion session with Dr. Abrams: Dangerous situations

Intro: The group discusses situations where they have intervened to help their friends in potentially dangerous situations.

Outro: Which opinions do you agree with? Which opinions do you disagree with?

Key areas:

- Even the best laid plans of staying with friends at parties do not always work out. You and all of your friends have to be on the same page with the plan as well.
- People who do not intervene are almost as guilty as the person engaging in the assaultive act.
- Intervening requires that a person not be intoxicated and be aware of what is going on, that they have the

courage to stand up and say something, and that they have the social skills to navigate the situation so that no one gets hurt.

Student discussion session with Dr. Abrams: Stereotypes about perpetrators of sexual misconduct

Intro: In this next clip, the group talks about stereotypes of who is a sexual offender, and whether athletes fit that stereotype.

Outro: Although stereotypes can be dangerous and clearly don't match every individual in a group, athletes do have higher rates of sexual assault on college campuses. Like the group says, sometimes being an athlete can give you protection, but it can also mean higher expectations. What aspects of athletics and sports culture contribute to negative masculine characteristics? Are there aspects of athletics and sports culture that contribute to positive masculine characteristics? As role models for youngsters, athletes should set a standard for zero tolerance for sexual aggression

Key areas:

- Most people think perpetrators are larger males or athletes.
- In larger schools with sports, athletes tend to be protected from the consequences of their actions.
- Stereotypes that athletes are more likely to engage in sexual assault.

MODULE 8

SESSION 1

Student discussion session with Dr. Abrams: Expectations in intimate relationships Part I

Intro: Do expectations that sexuality is part of a committed (i.e., "dating") relationship exist today? Is the concept of "item" (as in, they're an item) dying out? If so, are these expectations reasonable? It is often assumed that all relationships are monogamous, but it is obvious that that standard no longer exist today. Let's hear more about this.

Outro: People have different expectations, needs and desires in relationships. Whether it's a hook up or a long-term relationship, it's important to communicate your needs and limits to your partner, and to understand theirs as well. By having open communication about expectations and boundaries, you are more likely to have a sexual experience that is consensual, and that is fulfilling and pleasurable – for you and for your partner.

Key areas:

- There is external/societal pressure placed on individuals to be sexually active, especially in a relationship.
- Communicating needs/wants in an intimate relationship is imperative.
- In a relationship, both parties typically enter with several expectations, however they may not be the same.
- You want to be in a relationship because you want to be, not because you need to be.
- Everyone needs to be accountable for their own behaviors.

Student discussion session with Dr. Abrams: Expectations in intimate relationships Part II

Intro: Sometimes people have ideas or scripts of how things will go based on what is seen in the media. What drives attraction to another person? What influences one's expectations and beliefs about how social experiences will unfold?

Outro: Think about your own scripts and expectations that you have about sexual interactions. What characteristics do you find attractive in a romantic partner? What draws you to another person? What are qualities that you value and are important for your partner to possess? Do you agree with what the group discusses about unintended consequences? What are some cues, signs or "vibes" that would indicate that the person is interested in having a relationship or sexual encounter with you?

Key areas:

- At parties, men tend to gravitate towards woman who are dressed more provocatively and flirting with others.
- Some of the men discussed that sometimes women go out to party with the goal of having sex, and that men do not always realize that females have this plan.
- There can be a miscommunication of intentions – some people might be looking for a long-term relationship when they go out, and others may not.
- Attraction often starts visually, then continues or discontinues once two people talk to each other.

Student discussion session with Dr. Abrams: The Dating Game

Intro: A group member asks the women if there a certain type of guy that women avoid. These leads to a conversation that some people see dating and sex as a game. Games are fun after all, right? But if it's a game, what does winning and losing look like? Who are losers? What is the price of losing? Was the loser an active participant who just happened to lose, or a non-participating bystander who became the unwanted "object" of the game? Let's see what the group thinks.

Outro: Perhaps the ultimate objectification of women is using women as nothing more than a vehicle for enhancing your self-esteem through yet another sexual conquest. In this context, sex has nothing to do with your partner, only about you. The "Dating Game" is the ultimate, cynical portrayal of the male agenda. Winning,

from the guy's standpoint, is getting to home plate, getting "inside her pants," in-a-word, intercourse. What is "winning" from the woman's standpoint? It highly unlikely that winning means the same thing for women. It may NOT these days mean "romance," but it is quite likely that it means mutual pleasure, mutual satisfaction, occasional communication, perhaps caressing and not just humping, in a word – a "joint" experience that is mutually enjoyable. The words "joint" and "mutual" are used quite intentionally to suggest that the experience was something more than spreading your legs so the guy can have an orgasm and boast to his friends about it. As Dr. Abrams put it: If we call it a "game" when men and women flirt with one another, it trivializes bad outcomes, such as unwanted sex and sexual assault. The consequence of losing "the game" can be rape. If the end goal of the game is sex for one, not both parties, then it provides motivation for that one party to be aggressive in winning the game. It becomes a sexual assault version of Russian Roulette, which starts as a game and ends with deadly consequences." What do you think about this?

Key areas:

- Going to a party is like playing a game, however, interactions at parties do not always end in fun. Flirting can be fun, but if the end results are bad, calling it a game can trivialize the outcome.
- One participant mentioned that a person "wins" by achieving the highest social status.

SESSION 2

Student discussion session with Dr. Abrams: Relationship stereotypes

Intro: It's stereotypically assumed that men are only looking for sex and women want long-term relationships, but there are benefits to a relationship that are recognized and desired by both sexes. This clip breaks down the stereotype.

Outro: The men in this group say that they have female friends for whom they don't feel any sexual attraction but enjoy spending time with. In-other-words, non-sexual companionship can have its own rewards. Romantic relationships also provide them with companionship but in addition a degree of comfort and "personal intimacy" that they may not have in relationships with platonic friends. In college, though, the men say they feel pressure to place women into two distinct categories - women that are worthy of a relationship or women that are just for sex, with more pressure toward focusing on sex. What consequences might there to be to viewing women only as potential sexual partners? What are some problems with seeing women through a filter of these two categories? What could be lost?

Key areas:

- Being in a relationship with a female is different than hanging out with guy friends. In a relationship, you feel comfortable doing a lot of things, but with your friends, you might be afraid of being judged for some things.
- It is possible for guys to have non-sexual relationships with girls.
- There are guys who are looking for relationships (not just sex), and there are girls who are looking just to

have sex, and not have relationships. On college campuses, there might be more pressure for people to be looking for sex over relationships.

SESSION 3

Student discussion session with Dr. Abrams: Communication Part I

Intro: This next group discussion covers two basic concepts - attraction and communication. A party environment can sometimes lead to miscommunications between party-goers about intentions and expectations. Here the group examines miscommunication more closely.

Outro: It would be a mistake to assume that everyone's motives are sexual in initiating a conversation, even at a party. It can also be difficult to form an emotional connection in a party setting, especially if alcohol is involved, but the same rules need not apply in every situation where two people might meet. One rule that does apply: consent can never be assumed. What are some examples where consent might be incorrectly assumed based on someone's behavior?

Key areas:

- One person in a social conversation might just think the conversation is interesting, while the other person might think that they are "into them." It is difficult to interpret someone else's motives.
- Some people use alcohol to become more sociable.
- At parties, it is often a person's physical appearance that attracts people to talk to them.

Student discussion session with Dr. Abrams: Communication Part II

Intro: Technology has radically changed our mode of communication. Does our new "preferred" modes of communication – all relying on the Internet - make it easier to hide from difficult conversations, or does it make it easier to communicate? Let's see what the group thinks.

Outro: Communication often goes beyond the words people say. Communication includes the tone of one's voice, nonverbal gestures and facial expressions and occasionally looking directly into someone's eyes. All of these communication signals are lost in text messages. Cyber-communication is typically devoid of what is intrinsically human.

Key areas:

- Looking at your phone can make you less attentive to nonverbal cues.
- Frequent text messaging may often lead to miscommunications. How someone says something is often more important than what they say.

SESSION 4

College Student Discussion video

Intro: What follows is a scene with a group of students talking about sex and relationships with a clinician from the counseling center. As you watch, consider the different situations, challenges, and solutions they discuss in their conversations on the topic of negotiating safer sex that is consensual.

Outro: Students may experiment with many different types of relationships and sexual experiences. The students in this group discuss some of the challenges to negotiating safe, consensual sex with partners. Active listening and open, honest communication can help partners to convey what they like, what they don't like, and what their limits are. Think of what situations have come up in your own life where sexual communication felt really awkward or klutzy, or just plain amateurish. The art of lovemaking is only in the movies. Everyone feels a bit oafish at first. Nobody looks like or acts like or talks like the scripted actors in movies. The vast majority of us have some degree of performance anxiety and body image anxiety. Just remember, bumbling is far better than saying nothing. It is guaranteed to be appreciated. If nothing else, you will break the ice, and may even get a smile.

Key areas:

- Features a discussion with heterosexual and LGTBQ students.
- It is important to have conversations with your partner regarding sex and consent prior to engaging in any sexual activities .
- It can be difficult to have these conversations in the heat of the moment.
- It is also important to have conversations regarding pleasure and what feels good during sex; it is not good to just assume what someone likes or does not like. It can be difficult or embarrassing to discuss, but there are ways to make the conversation sexy or fun and playful.
- Responding to nonverbal cues is important. Further, if someone says no to something regarding sex, you should stop.
- Communication is key.

Student discussion session with Dr. Abrams: TITLE IX

Intro: Title IX is part of the Equal Rights Act requiring any institution/organization that receives federal funding to insure equality. As you may have heard, there have been quite a few lawsuits about sexual assault cases on college campuses. Let's see what these students know about Title IX.

Outro: Title IX not only pertains to sports, but to all other aspects of the institution, including, importantly, sexual misconduct on college campuses. Campuses must be a safe environment for all students. From your own perspective, think about what the campus life would be like for you if you didn't feel safe?

Key areas:

- Sexual assault victims have sued schools under Title IX, arguing that the perpetrator would not be on campus if it was not for the scholarship he received.

SESSION 5

Student discussion session with Dr. Abrams: Confirming consent

Intro: Is consent something that is given in a moment in time, or is it something that can change? Can the way someone is dressed indicate that they want to have sex? These are the topics the group discusses in this next clip.

Outro: As we heard, it's normal to have mixed feelings about sex, to have desires but be unsure whether you want to proceed, or to proceed and then regret having had sex afterwards. What is important is whether consent was clearly given at the time. This is why communication is crucial when it comes to consent. Consent cannot be inferred from what the victim is wearing or from the victim's decision earlier in the evening, such as choosing to come to the party or choosing to accept your invitation to have a beer – or two, or to accept your invitation to dance, or even to accept your invitation "to go upstairs." Going upstairs is not synonymous with sex. That is why communication is crucial. Communication need NOT be complicated, awkward, embarrassing or feel stupid. A simple "Are you comfortable with this?" as you are disrobing can be adequate. As Dr. Abrams says, if you get a "yes" then it's a yes, and anything else is a "no." Consider the different ways to get consent either beforehand and during sexual activities.

Key areas:

- Dressing a certain way for attention does not mean that a woman is consenting to having sex.
- Consent can change over time.
- Coercion and pressure are often used to try to get someone to have sex (e.g., "if you loved me...").
- Regret the next morning does not mean that sexual assault occurred.
- If you do not get an explicit yes, it is a no.

Student discussion session with Dr. Abrams: Sexual satisfaction

Intro: In this next clip, the group discusses sexual satisfaction and whether or not men are socialized to put their sexual needs first, and how that effects the treatment of women.

Outro: The group has some interesting things to say about "mutual satisfaction," the objectification of women and where it potentially stems from. Do you agree that social media gives the message that men's needs are more important, and women's needs are secondary? Do you think that today's sexual "climate" and sexualized media has distorted relationships between men and women?

Key areas:

- Mistakes are accidents; assault is a bad decision. In the moment of an assault, someone decided that what he or she wants is more important than what anyone else wants.
- One person offered the thought that two people can have sex for purely selfish reasons (e.g., just wanting to "get off," instead of wanting the other person to have a good time). Sexual assault is selfish; the perpetrator is out for his or her own pleasure.
- Social media and cellphones can lead to misunderstandings and miscommunications about intentions.

Student discussion session with Dr. Abrams: Consent Part I (also can use in Module 2)

Intro: What exactly is consent? How do you know if someone has given consent, or is even capable of giving consent? The group discusses the nuances of consent in this clip and situations when it's ambiguous.

Outro: Some may think consent isn't always clear, however a clear "yes" is necessary. "Yes" means yes, "no" means no, and "maybe" can mean no as well. A person can say "no" at any time, even if they had previously said "yes." Often sex, especially when it's the first time with a particular person, IS a big deal. How do you know for sure that the person is consenting in the heat of the moment?

Key areas:

- The issue and definition of consent are discussed.
- How does consent interact with the law in regard to sexual behaviors? Consent means something specific when talking about the legal system.
- The group discussed the role of alcohol and the effect it may have on an individual's ability to consent.
- The presumption of consent is that an individual has the ability to consent to sexual behaviors until proven otherwise (or under certain circumstances).
- The group discussed the circumstances/conditions where consent to sexual behaviors may not be available. How do you determine the ability for someone to give consent?
- During ambiguous situations, consent should not be assumed.
- The "state of mind" of an individual matters in their ability to give consent (i.e., alcohol or drug use may impair the individual to properly give consent).
- Consenting to sexual behaviors can be complex: "maybe", mixed messages, or anything other than a clear "yes" should be interpreted as a "no".
- Consent has to be in the affirmative, if there is any uncertainty, then it is a "no".
- The concept and phrase "blue balls" and how it is uncomfortable, but it is not fatal and the misconception that men have about this phenomena.
- The "blue balls" and entitlement/ the right to "finish" or ejaculate.

Student discussion session with Dr. Abrams: Consent Part II (also can use in Module 8)

Intro: In this clip, the group was talking about consent, but what about when drinking is involved? Or in situations when people have already had sex in the past? Does consent work the same way? Let's hear what the group thinks.

Outro: Whether it's sex for the first time or not, consent is always something that must be obtained, and as Carlos said, "consent is something that should be given every time." How do you have that discussion? Is "discussion" realistic in every situation? In other words, do people really have "a discussion" beforehand or at the moment? How do you shift to "discussing" consent when you're in the middle of undressing each other? If someone appears to be allowing herself to be undressed, does that imply that she is consenting? Can consent really occur in "the heat of the moment"? In what ways is consent between two people that are drinking at a party complicated? What about expectations of sex in a long-term relationship or marriage? How does consent work in relationships and marriages?

Key areas:

- Someone has to have the affirmative ability to consent to sexual activity. If there is any type of reason that significantly interferes with a person's ability (ie, intoxication or drug use) it should be assumed that consent for sexual activity cannot be given.
- In the instance of a male or female being too intoxicated, there is a distinct difference between other observers "taking care of" him/her or "taking advantage of" him/her.
- There is a misconception that due to previous sexual engagement with a partner, an individual does not have to achieve consent for future sexual behaviors. Consent should be given every time sexual activity may occur.
- Every intimate sexual activity is like a "contract" where both individuals agree to engage in the sexual activity. Discussion of how to execute this "contract". Consent should be obtained each time two people engage in a sexual act.
- Being in a relationship with someone does not guarantee that sex will occur every night. Consent should never be assumed, even if two people are married or in a long-term relationship.
- In relationships, there should be the established dialogue between partners for when sexual activities will occur. Both individuals in the relationship should know their partner well enough to make sure that they are "into it" or ask if they want to engage in sexual activity, there should be vocalization of "yes" or "no" when consenting to any sexual activity.

Student discussion session with Dr. Abrams: Consent Part III (also can use in Module 8)

Intro: Consent can be revoked at any time during a sexual encounter, but if partners already have difficulty understanding consent, this becomes complicated. The men in this group discuss some concerns they have about the process of obtaining consent, raising some important questions, including issues and concerns about the legal system.

Outro: This clip covered the complexity of obtaining consent in the moment as a sexual encounter unfolds. Dr. Abrams posed the question about how to ensure that you have consent as sexual activity progresses, in the

moment. Throughout a sexual encounter, there are verbal and nonverbal ways in which both partners reaffirm their consent. Sometimes, though, partners are unable to, or are uncomfortable with, speaking up if they do not like something, if something is painful, or if they simply want to stop. Checking in becomes important because of these instances. Intoxication may lessen a partner's awareness and lead to an impaired ability to check in. What are some signs that might indicate consent – or lack of consent? What signs indicate discomfort? What are some things you can do in the moment to confirm consent?

Key areas:

- Asking a partner during a sexual act if they consent from moving from "first base" to "second base" and so forth. In other words, how can consent be achieved in each variation of sexual behaviors when engaging in an intimate act, and how may it be clear that both partners want to progress to another part of the sexual act.
- Communicating with your partner that you do not want to go further with the sexual activity is essential.
- Communication of consent to progress into another part of the sexual act may occur by verbally asking them to stop, or physically pushing away from your partner.
- The issue with reading the "signs" of whether your partner wants to engage in a certain sexual activity. This can occur for both males and females, especially if intoxicated, and these signs may become difficult to interpret.

Student discussion session with Dr. Abrams: Consent Part IV (also can use in Module 8)

Intro: Our notions of what "consent" means may be influenced by the media (i.e. TV and social media). The media rarely, if ever, portrays communication between a couple that reflects consent. Either consent is assumed, or the encounter obviously is unwanted and constitutes some form of sexual assault.

Outro: Among many other aspects of how we view ourselves, media clearly can influence our ideas of what masculinity "looks like" or what it means to be "masculine." Thinking about how we develop our beliefs and what factors shape our ideas and attitudes about gender roles, masculinity, and sex is important to understanding ourselves. Not surprisingly, it is also critically important in developing healthy relationships with partners. In what ways do you think that the media influences your notions of what appropriate and inappropriate sexual behavior is? Do you feel that you have beliefs or attitudes about gender roles, masculinity and sex that you might want to change?

Key areas:

- How has social media, TV shows, or movies portray the "bad guy" that all women "want" and how does this effect men's perception of engaging in a conquest for sexual activity with a female?
- The social constructs of "chivalry" or being a "good guy" are discussed and how getting the attention of females or consent for sexual activity may be misperceived. In other words, men may perceive women wanting the "bad guy" and when engaging in sexual behaviors men may behavior this way, instead of achieving consent.
- The misconception and expectations of the media and how women and men are supposed to dress or

behave towards one another is discussed.
- The group discusses the definition of and the pressures for men to be influenced by these expectations.
- The development of male maturity and the ability to learn from the proper definitions of masculinity or proper role models.
- The group discusses the importance of males learning to express emotions and solve problems without physical violence.

Student discussion session with Dr. Abrams: Alcohol and consent (also can be used in Module 2

Intro: Intoxication by alcohol or other drugs impacts judgement and perception. Alcohol can decrease a person's understanding of consent and help pave the way to unwanted sex, but education can serve as a buffer to prevent negative consequences. Here, the group is given an important lesson.

Outro: A "maybe" or a "probably" or a shrug or a nod or even a smile does not constitute a "yes." A "yes" can't be assumed, especially when one or both partners are intoxicated. Communication is an important part of sex but some factors, like alcohol intoxication, decrease the likelihood of it being clear. If there is any doubt about whether a partner is willing or able to consent to sex, it's always better to stop or wait. What might be some other signs to stop? What are some nonverbal signs that a person isn't into it? Or simply that the person is incapable of protesting? What other factors indicate that a partner can't or doesn't consent?

Key areas:
- A person's ability to read nonverbal cues, and interpret intentions, becomes impaired when they are intoxicated.

MODULE 9

SESSION 1

Student discussion session with Dr. Abrams: Accountability

Intro: Accountability is often mentioned in conversations about sexual assault, but it is not usually discussed among friends who could act to prevent assault from occurring. Why not? How can we increase accountability? Here, the group shares some ideas.

Outro: Men learn from a young age that their self-esteem as men often derives from approval by others, especially their peers, it can be all the more difficult to speak up when peers express troubling ideas, ideas

that you may really disagree with. What do you consider masculine? Where do your opinions of masculinity come from? How do unhealthy ideas about masculinity contribute to not accepting responsibility for harmful behavior, including sexual assault? How might this be changed within peer groups? Have you ever seen it done?

Key areas:

- There are many men who learn from their role models that hypermasculinity is correct (e.g., you should be tough and strong, hide your emotions, and girls will just come to you; your value is based on your conquests).
- Some people who were raised the "right way" engage in bad behavior either because they have a poor peer groups, or they were not about accountability for their actions.

SESSION 2

Student discussion session with Dr. Abrams: Supporting victims of sexual assault

Intro: People who were sexual assaulted are looking for supportive communities, but often find disbelief or blame instead. In this clip, the group discusses some strategies for support.

Outro: Often, we focus on the ways that institutions like law enforcement fail survivors, but it's just as important, if not more important, that we examine our own failure to be supportive. Responding with empathy, rather than cynicism or anger, can be difficult, especially when you feel pressure to express the same thoughts and feelings of your peers. In an environment where support is evident, survivors will be more willing to come forward and seek the help they need. What examples have you seen of support and non-support of survivors of sexual assault?

Key areas:

- Many of the participants brought up the importance of supporting their friends if they have been assaulted (e.g., helping them go to the police, talking with them).
- Dr. Abrams brought up the importance of having people who are trained to investigate sexual assault do the actual investigations instead of campus police.
- It is important to default to "this is true until proven otherwise," when hearing an account of sexual assault.

Student discussion session with Dr. Abrams: Prevention of sexual assault on college campuses

Intro: What can we do beyond prevention to stop sexual assault on college campuses? College campuses and society at large have a responsibility to prevent sexual assault. They are also responsible for helping with recovery after an assault occurs, working with both the victim and the person who committed the assault. The group has some ideas here for how these issues could be handled better.

Outro: Damaging ideas endorsed by peer groups, apathy, a failure to intervene, and a lack of resources all contribute to the existence and continuation of sexual assault. Though universities and other institutions can do a better job of providing programming, training, support, and "consequences," we also have to consider how to challenge existing societal norms. By discussing honestly and openly the problems and challenges that we face, each of us can play a part in healing our communities and preventing further sexual assault. What role can you play in your own life to help mitigate harmful sexual behavior?

Key areas:

- It is important to teach empathy.
- Some participants brought up the point that administrators might not care about an assault until it impacts the university (e.g., enrollment, reputation).
- It is important to have a more efficient policing system in order to have more convictions of guilty offenders.
- To treat perpetrators and prevent future assaults, it is important to understand the risk factors and what leads to the behavior. It is not enough to treat only the behavior.

Student discussion session with Dr. Abrams: The power of peer engagement

Intro: What can you do to impact change? Part of creating change and reducing campus sexual assault begins with communication, having meaningful conversations about campus sexual assault. Dr. Abrams talks about the importance of communication as an agent to change attitudes and behaviors, particularly the importance of conversations between college peers.

Outro: Think about conversations that you have with your peers at college and how these conversations might be avenues to start productive dialogues that can affect change. These can include conversations about the prevalence of campus sexual assault, stereotypes or attitudes that support sexual misconduct, risky behaviors and situations, and rationalizations that minimize the severity of thoughts and behaviors related to sexual misconduct.

Key areas:

- Speaking out against sexual assault is most effective when it comes from peers.

Returning to Campus video

Intro: What follows is a scene with a family getting ready to take their son to the airport. He is getting ready to go back to college after finishing a one year suspension for sexual misconduct.

Outro: The student and his parents have mixed feelings about his return to campus. On one hand, he felt that therapy helped him to identify what lead to the sexual misconduct and that he knows how to move forward

with making healthier decisions. On the other hand, he knows it's a lot easier said than done. Returning to campus and fitting in could be tough. How will I react to seeing friends who encouraged the sexual misconduct? How do I respond to friends who don't know and ask where I've been? What will I say to all the kids I used to hang out with who may be critical of what I did? Or the opposite, blow it off, and say the whole thing was stupid, and I got the shaft, or burned by someone? And what about all the girls on campus that knew me? What am I supposed to say to them when they say "Hey, where've you been?" It sure isn't going to stay a secret. The news will spread like wildfire. What am I supposed to say? "Yeah, I was kicked off campus when this girl said I sexually assaulted her, but I'm cool now." I'll be a pariah. Forget any social life. I might as well tattoo R on my forehead. Despite these challenges and concerns, a student with help and support can successfully return to campus. It is important that you raise these concerns and discuss your feelings with your provider during treatment so you can develop a plan and put support systems in place on campus.

Key areas:

- Treatment can be required prior to a student returning to campus.
- Reintegration into the campus community can be difficult for the student (e.g., nerves, being away for so long).
- Therapy can help the student make sense of what happened.
- It is important to separate from negative peers.

ADDITIONAL MULTIMEDIA RESOURCES

Full-Length Movies

The Hunting Ground (Netflix- streaming)

It Happened Here (Netflix- streaming)

Tough Guise: Violence, Media, and the Crisis in Masculinity (YouTube)
https://www.youtube.com/watch?v=3exzMPT4nGI

Audrie & Daisie (Netflix- Streaming)

Shorter Videos

Finally, Date Rape Ads that Put the Onus on the Raper
http://www.buzzfeed.com/copyranter/finally-rape-ads-that-put-the-onus-on-the-raper#.cbbv2n18g

A Call To Men- Tony Porter TedTalk
http://www.ted.com/talks/tony_porter_a_call_to_men

Be A Man: Joe Ehrmann at TEDxBaltimore 2013
https://www.youtube.com/watch?v=jVI1Xutc_Ws

Violence Against Women: It's a Men's Issue – Jackson Katz TedTalk
http://www.ted.com/talks/jackson_katz_violence_against_women_it_s_a_men_s_issue

University of Arizona – Men Against Sexual misconduct
(https://www.youtube.com/watch?v=6CBIwqXPCM0)

Sex Needs a New Metaphor: Here's One –Al Vernaccio TedTalk
http://www.ted.com/talks/al_vernacchio_sex_needs_a_new_metaphor_here_s_one

If We Treated Things Like We Treat People During Sex: A Consent Video by Buzzfeed
https://www.youtube.com/watch?v=bhgT2JWwCC4

Consent, Explained by a Porn Star: A Consent Video by Buzzfeed
https://www.youtube.com/watch?v=JEAgXMtcJ0w

Communicating Consent College Series
https://www.youtube.com/watch?v=GQ_5IxKAc3E&feature=youtu.be
https://www.youtube.com/watch?v=tA9YitaWm9A&feature=youtu.be
https://www.youtube.com/watch?v=f3h5ncnaXng

Tea as Consent Video
https://www.youtube.com/watch?v=oQbei5JGiT8

Sex Education: Last Week Tonight with John Oliver
https://www.youtube.com/watch?v=L0jQz6jqQS0

Sexualization in Society and its Effects (Examples and Research)
https://www.youtube.com/watch?v=jU2WzCjTkF4&feature=related

Sexualizing America
http://www.youtube.com/watch?v=jU2WzCjTkF4&feature=related

Blog Posts and Articles

Consent Must Be Created, Not Given
http://time.com/99602/campus-sexual-assault-jonathan-kalin/

What is Consent? What Isn't Consent?
http://www.consentissexy.net/consent

What Consent Looks Like
https://www.rainn.org/articles/what-is-consent

Son, It's Okay if You Don't Get Laid Tonight (letter included below)
http://angieup.tumblr.com/post/64577581035/son-its-okay-if-you-dont-get-laid-tonight

7 things that have nothing to do with rape perfectly illustrate the concept of consent (article included below)
http://www.upworthy.com/how-7-things-that-have-nothing-to-do-with-rape-perfectly-illustrate-the-concept-of-consent?c=ufb8&s=p

On Campus: Drinking to Blackout
http://www.nytimes.com/2016/09/19/opinion/drinking-to-blackout.html?_r=0

No Kegs, No Liquor: College Crackdown Targets Drinking and Sexual Assault
http://www.nytimes.com/2016/10/30/us/college-crackdown-drinking-sexual-assault.html

Here's Why We Need to Talk to Men About Violence Against Women
http://shriverreport.org/heres-why-we-need-to-talk-to-men-about-violence-against-women-jackson-katz/

Rice Video Accelerates Cultural Shift on Men's Violence
http://www.huffingtonpost.com/jackson-katz/rice-video-accelerates-cu_b_5812366.html

Safer Sex
http://www.sexualityeducation.com/pdf/safersex.pdf

Safer Sex for Bisexual People and Their Partners
http://www.sexualityeducation.com/pdf/safersexbi.pdf

Beating Around the Bush: Sexuality Information for Lesbian and Bisexual Women
http://www.sexualityeducation.com/pdf/safersex.pdf

Safe Partying and Safe Sex
http://lgbtrc.uci.edu/resource-library/safety-info/index.php

Johnathan Kalin - How Men and Boys Can Help Create a World with No Ceilings
https://www.clintonfoundation.org/blog/authors/jonathan-kalin

Top 10 Safer Sex Tips for College Students
http://students.colum.edu/articles/2013/Fall/top-10-safe-sex-tips.php

APPENDIX G

Sample Treatment Completion Summary

SAMPLE TREATMENT COMPLETION SUMMARY

***Only copies that have redacted identifying information should be submitted to the pilot program.**

Name: _____

Age: _____ **Date of Birth:** _____

Period of Treatment: Start _____ Completion _____

Specify (circle one): Completion Premature Discharge Transfer

*** If client did not successfully complete the program, please specify the reasons why not below.**

Number of Completed Sessions: _____

Referral Source and presenting problems:

- Reason for Referral (briefly discuss referring institution's reports of the sexual misconduct, sanctions, and request for treatment participation)
- Did the provider receive a Contributing Factors Checklist (CFC) for the student (circle): **Y N**

Treatment Engagement

- Specific number of sessions and duration of treatment period in months
- Note whether the client successfully complete treatment

- Considerations include: treatment motivation, engagement & compliance, e.g., attended as agreed upon, number of missed sessions without prior notification or good cause, completed between session treatment assignments minimally, satisfactorily, beyond expectations.
- General statement about treatment gains and progress towards treatment goals and objectives (i.e., increased understanding of the problem of sexual misconduct, aware the factors that contributed to his/her misconduct, development of victim impact perspective and empathy).
- General statement about attitudinal and behavior change.

Treatment Progress

(rate the extent to which the student has resolved identified risk factors associated with sexual misconduct).

Limited		**Moderate**		**Satisfactory**
1	2	3	4	5

Recommendations

None at this time (circle)

Supportive services on campus, or within the community, such as: _____

Continued/additional services, (e.g., substance abuse treatment): _____

Independent follow up risk and needs assessment (circle)

Provider:_____ Date: _____

Name (print): _____

Title: _____

Address: _____

_____

APPENDIX H

Adjunctive Treatment Interventions

ADJUNCTIVE TREATMENT INTERVENTIONS

Treatment must be delivered in ways that promote treatment responsiveness. As such, interventions are multi-modal and include activities such as brainstorming, using games or creating games or using art to learn and practice concepts and skills; utilize role plays to increase opportunities for rehearsing and improving positive behavior strategies and active practice assignments between sessions. In addition, viewing relevant movies, television shows and listening music, and providing relevant critiques, can be useful. Other activities may include interviewing or meeting with community leaders on relevant topics to reinforce learning and build prosocial mentors and relationships.

Sometimes medication is an important component of a holistic treatment approach. Appropriate referrals for psychiatric assessments, and medication if indicated, should occur.

http://www.samhsa.gov/treatment/mental-disorders

PTSD:

- Exposure therapy
- Cognitive Processing Therapy
- Cognitive restructuring
- Psychological therapies

Bipolar Disorder:

- Cognitive-behavioral therapy
- Interpersonal and family therapies
- Psychoeducation

Depressive Disorders:

- Interpersonal therapy
- Cognitive-behavioral therapy

Anxiety Disorders:

- Cognitive-behavioral therapy
- Mindfulness therapy

Exposure therapy

- Exercise and relaxation techniques

Substance Use Disorders:

- Cognitive-behavioral therapy
- Contingency management
- Motivational enhancement therapy
- 12-step facilitation therapy
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) - http://www.samhsa.gov/sbirt

Personality Disorders:

- Dialectical Behavioral Therapy (DBT)
- For youth with substance use disorders:
  - Adolescent Community Reinforcement Approach (ACRA)
  - Assertive Continuing Care (ACC)

Co-Occurring Disorders:

- Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit - http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367
- http://www.samhsa.gov/disorders/co-occurring

Treatments for Serious Mental Illness (SMI):

- http://nrepp.samhsa.gov/Docs/Literatures/NREPP%20Learning%20Center%20Literature%20Review_%20Serious%20Mental%20Illness.pdf

American Psychological Association- Division 12:

- Empirically Supported Treatments
- http://www.div12.org/psychological-treatments/

APPENDIX I

Sexual Misconduct Contributing Factors Checklist (CFC)

SEXUAL MISCONDUCT CONTRIBUTING FACTORS CHECKLIST (CFC)

Overview:

The CFC is designed to inform decision making regarding the final sanctioning plan for students found responsible for the full range of sexual misconduct. This includes intimate partner violence, dating violence, stalking, and other sex or gender-based misconduct when the acts have a sexual element. The CFC is a checklist that highlights a wide range of incident-related characteristics and Respondent characteristics that are associated, in varying degrees of importance, with the perpetration of sexual misconduct, as well as a few protective factors that may reflect potential strengths and enhance the Respondent's receptivity to intervention. Although the CFC items focus primarily on characteristics of the incident for which a student has been found responsible, five other areas are included: prior misconduct, alcohol and peers, impersonal behaviors, hostility, and possible protective factors.

Instructions:

The CFC is intended to be completed by student conduct professionals or institutional designees who determine the sanctions that will be imposed on the responsible student. The CFC is intended to be completed after a finding of responsibility for sexual misconduct. The CFC is completed based on all available information from the Complainant, the Respondent, witnesses, the institution, or any other relevant documentation. No interviews are required. It is recommended, when possible, that two or more individuals complete the CFC independently and then discuss any disagreements in their rating of each item.

Items are rated by checking the appropriate box. “Yes” indicates that an item is present and “No” indicates that the item is absent. If an item is clearly not applicable, specify “N/A” in the “No” box. Specifying “No” alone could be misleading (i.e., implying the absence of a factor that was Not Applicable). For example, items #10 and #11 of Incident Characteristics ask about Gratuitous Violence and Escalation of Violence. If there was no evidence of physical violence, rating these items as “No” could suggest that violence was present but not gratuitous violence or increasing (escalating) force in response to resistance. In this case, “N/A” would be more appropriate. The “?” box indicates that an item is possibly present, but there is insufficient information for the item to be rated reliably. We recommend that all items be addressed.

Although Incident Characteristics obviously apply only to the Incident under review, other areas are not restricted to the Incident and may be rated based on all available information. The word “BOTH” is included to denote that the rater should consider incident characteristics and other behaviors/events independent of the

reporting incident. CFC factors are not weighted. Some factors, however, are bolded denoting that they clearly are more concerning and likely reflect greater needs that would be more adequately addressed in treatment than psychoeducation.

After rating all items, evaluators are encouraged to note their most salient concerns regarding the Respondent's behavior in the Summary section, along with any observed strengths or protective factors, and any other information useful to understanding the individual's historic, current, or future status. Although the presence of many positively rated factors may indicate greater needs, and suggest a referral for treatment, all factors pertinent to the individual should be considered. A student with multiple protective factors, for whom there seems to be a core knowledge or skills deficit, may be adequately served by the psychoeducation program.

If a student is referred to the STARRSA treatment or active psychoeducation program as a component of the sanction plan, the institution is encouraged to provide a copy of the CFC to the treating clinician or facilitator within the limits of the institution's policy and applicable law governing data sharing.

Notes:

The CFC is not a risk assessment instrument that is designed to predict whether a student will engage in future sexual misconduct. It has not been developed or validated for that purpose. It is intended only as a checklist of factors to be considered prior to sanctioning a student for sexual misconduct.

In some instances, the CFC may contain information that appears to contradict the institutional record. For example, if a Respondent was accused of non-consensual sexual penetration and sexual harassment, the institution could find the student responsible for only sexual harassment. In these instances, the CFC should be completed to reflect the initial report rather than the institutional finding so evaluators give due consideration to all available information and circumstances that could inform their sanctioning decision.

SEXUAL MISCONDUCT CONTRIBUTING FACTORS CHECKLIST (CFC)*

Name: _____

Person(s) Completing CFC: _____

Date Completed: _____

INCIDENT ONLY CHARACTERISTICS	YES	NO	?
1. Any non-consensual, non-contact sexual conduct such as unwanted sexual remarks			
2. Any verbal pressure to have sex stopping short of threatening physical harm			
3. Any verbal threats of physical harm directed at Complainant			
4. Any non-consensual sexual touching			
5. Any stalking of Complainant before or after incident			
6. Any non-consensual oral, anal, vaginal penetration by the penis, fingers or objects			
7. Were there multiple acts of penetration or more than one form of penetration within the same incident			
8. Any non-consenting sexual acts involving multiple perpetrators			
9. Any physical force, including use of body weight differences			
10. Was the violence gratuitous [i.e., clearly exceeded what was minimally necessary to force sexual contact (i.e., commit the sexual misconduct)]			
11. Did the violence level escalate (i.e., increase), such as kicking, punching, or choking, in response to resistance over time during the incident			
12. Any injury to Complainant such as bruises, abrasions or sprains			

13. Was the incident reported to local police (campus or community)			
14. Did Complainant receive medical care			
15. Was forensic evidence gathered via a "rape kit"			
PRIOR MISCONDUCT	**YES**	**NO**	**?**
1. Any prior reports of academic misconduct			
2. Any prior reports of physical aggression (e.g., fighting)			
3. Any prior reports of non-consensual sexual kissing, touching, groping or other contact sexual misconduct			
4. Any prior reports of using threats of harm or physical force, even minimal, to coerce non-consensual, penetrative sexual acts			
5. Any prior reports of non-academic conduct violations other than those mentioned above			
ALCOHOL AND PEERS (BOTH)	**YES**	**NO**	**?**
1. Any pressure on Complainant to drink alcohol			
2. Was Complainant intentionally given a spiked drink/drinks without Complainant's knowledge (e.g., evidence that respondent knowingly gave the Complainant a drink with drugs with the intent of facilitating sexual misconduct)			
3. Any pressure on Complainant to consume drinks spiked with other drugs			
4. Did incident take advantage of an already intoxicated, stoned or otherwise incapacitated Complainant who was unable to consent (e.g., Respondent committed the sexual misconduct knowing that the Complainant was impaired from drugs or alcohol)			
5. Was Complainant unconscious, passed out or asleep during all or some of the incident			

6. Any signs of excessive routine use of alcohol by Respondent, as evidenced by the number of days per week Respondent ingests alcohol and/or indications of binge drinking (more than 5 drinks per occasion)			
IMPERSONAL BEHAVIORS (BOTH)	**YES**	**NO**	**?**
1. Complainant was a stranger			
2. Complainant was known or recognized and Complainant did not have any prior consensual sexual activity with the respondent.			
3. Any involvement in recording pictures/videos of the incident			
4. Any posting on Internet, or emailing/texting about the incident			
5. Any remarks in which it seemed as if Respondent was conceited, bragging, boasting, or trying to impress the Complainant or other students/peers			
6. Any remarks by Respondent to peers that suggested incident was viewed as a "sexual conquest"			
7. Respondent evidences no concern for Complainant			
8. Respondent is known or suspected to associate with other students/friends/ housemates that promote sexual "conquest" (including residence in an apartment or house that was the setting of other complaints in the past)			
9. Respondent did NOT use a condom			
10. Respondent typically chooses sex partners based primarily on sexual availability, without emotional or other attraction as selection criteria.			
HOSTILITY (BOTH)	**YES**	**NO**	**?**
1. Use of verbal coercion or pressure that was highly manipulative, e.g., implying that sex was "owed," or an "obligation" or "expected"			
2. Any statements during or after the incident that blamed the Complainant, such as "you like this," "you deserve this," or "you wanted this"			
3. Any demeaning, degrading, or disparaging name-calling that was gender or sexual-orientation-focused, such as whore, bitch, cunt, twat, slut, queer, lezzie, dyke, fairy, fag/faggot			

4. Any statements intended to demean or degrade the Complainant's race, ethnicity, religion or personal characteristics (such as being overweight)			
5. Verbal threats of harm directed at Complainant			
6. Respondent's responses reflected general anger at the Complainant and/or the institution			
POSSIBLE PROTECTIVE FACTORS	**YES**	**NO**	**?**
1. Respondent appears to accept responsibility for the incident			
2. Respondent is currently involved in counseling/therapy			
3. Respondent expresses willingness to be in therapy around the current incident			
4. Respondent has a moderate to strong academic record			
5. Respondent appears to express some genuine degree of regret, remorse, or contrition			
6. Any remarks by Respondent to peers that suggested incident was viewed as a "sexual conquest"			

*Information derived from the CFC is strictly intended only for internal use by the institution for consideration of what an appropriate sanction for the misconduct might be and, if specialized treatment or psychoeducation is recommended or required as part of that sanction, for use by a subsequent therapist / clinician or psychoeducation facilitator. Information should be shared with clinicians and facilitators only as permitted by institutional policy and applicable law, including the Family Educational Rights and Privacy Act (FERPA).

APPENDIX J

Resources for Service Providers

- Factsheets
- Organizational websites
- Guidelines

FACTSHEETS

What you need to know about campus sexual assault perpetration.
Administrator Researcher Campus Climate Collaborative

http://rjcenterberkeley.org/wp-content/uploads/2015/05/Facts-about-perpetration_04-08-15-copy.pdf

What you need to know about campus sexual assault victimization.
Administrator Researcher Campus Climate Collaborative

https://ranenetwork.com/wp-content/uploads/2018/02/Facts-about-victimization-with-logo_07_-01_2015.pdf

ORGANIZATION AND INFORMATIONAL WEBSITES

Male Athletes Against Violence
http://umaine.edu/maav/

Party with Consent
http://partywithconsent.org/

Men Can Stop Rape
http://www.mencanstoprape.org/

Consent is Sexy
http://www.consentissexy.net

Affirmative Consent and Yes Means Yes
http://www.affirmativeconsent.com

LGBT Foundation
http://lgbt.foundation

GUIDELINES, BOOKS AND INTERNET RESOURCES

American Psychological Association. (2012, January). Guidelines for Psychological Practice Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, American Psychologist, 67(1), 10-42).
http://www.apa.org/pi/lgbt/resources/guidelines.aspx

American Psychological Association. (2015, December). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. American Psychologist, 70 (9), 832-864.
https://www.apa.org/practice/guidelines/transgender.pdf

Association for the Treatment of Sexual Abusers (ATSA)
http://www.atsa.com/
ATSA has guidelines and resources available

Center for Sex Offender Management (CSOM)
http://www.csom.org/
CSOM has various resources available

RAINN (Rape, Abuse & Incest National Network)
https://www.rainn.org/

Stinson, J. D., & Clark, M. D. (2017). Motivational interviewing with offenders: Engagement, rehabilitation, and reentry. New York, NY: The Guilford Press.

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