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Author(s): Robert Prentky, Ph.D., Mary Koss, Ph.D.
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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

Principal Investigator
Robert Prentky, PhD
Fairleigh Dickinson University

Co-Principal Investigator
Mary Koss, PhD
The University of Arizona
This is a draft of the Cognitive Behavioral Therapy (CBT) Treatment Manual developed for clinicians who are retained to work with students that are found responsible for sexual misconduct by Title IX officers as part of a student conduct recommendation or sanction. Prior to starting, all clinicians participating in the pilot should have received direct training from the STARRSA team, signed a confidentially agreement and received confirmation that they have been added to the DOJ issued privacy certificate. If you are participating in the pilot and are unsure whether or not you meet these criteria, please contact the Project Managers Raina or Elise.

It is a pilot version, and as such, may be expected to go through multiple revisions over the next year following the feedback received from the pilot sites and clinicians.

The following senior project staff and consultants contributed to the STARRSA project treatment and materials development:

Mitch Abrams, Psy.D., University Correctional HealthCare - Rutgers University
Judith Becker, PhD, The University of Arizona
Ariel Berman, MA, Western Michigan University
Ann Wolbert Burgess, D.N.Sc, Boston College
Peter Economou, Ph.D., Felician University
Mark Huppin, J.D., Ph.D., University of California – Los Angeles
Mary Koss, PhD, co-PI, The University of Arizona
Raina Lamade, PhD, Project Manager, Fairleigh Dickinson University
Elise Lopez, DrPH, co-PM, The University of Arizona
Neil Malamuth, Ph.D., University of California – Los Angeles
Robert Prentky, PhD, P.I., Fairleigh Dickinson University
Sue Righthand, PhD, The University of Maine
Barbara Schwartz, PhD, BOP Maine
Jay Wilgus, JD, M.D.R, Consultant
SMART DOJ GRANT: Campus Sexual Misconduct: Using Perpetrator Risk Assessment and Tailored Treatment to Individualize Sanctioning

STARRSA (Science-based Treatment, Accountability, and Risk Reduction for Sexual Assault) Program

Project Personnel and Management

Please contact Project Managers, Raina or Elise, with any project questions, assistance with administration. For clinical and treatment implementation questions, please contact Raina.

Principal Investigator
Robert Prentky, Ph.D.
Fairleigh Dickinson University
201-692-2649
rprentky@fdu.edu

Co-Principal Investigator
Mary Koss, Ph.D.
University of Arizona
520-626-3998
mpk@email.arizona.edu

Project Manager
Raina Lamade, Ph.D.
Fairleigh Dickinson University
(201) 397-5559
(631) 748-7687
lamade@fdu.edu

Project Manager
Elise Lopez, DrPH
University of Arizona
520-621-4916
eclopez@email.arizona.edu
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Preface

A Starting Point for Understanding Campus Sexual Misconduct: The Perfect Risk Storm:

College students are clearly a high risk group for rape (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) observed a quarter century ago that, “An extensive literature documents the high rates of acquaintance rape on college campuses,” (p. 165). Berkowitz (1992) similarly noted, “A substantial proportion of college women are at risk of becoming victims of acquaintance rape on campus,” (p. 175). The explanation would seem to be best captured by the remarkable number of converging risk factors that forge something of a perfect storm for rape on college campuses:

(1) **College Students / Social Culture:** In colleges, there is an abundance of very young adults in their sexual prime who are drawn to a social culture that promotes, and indeed places emphasis on, informal, casual “dating” (“hooking-up,” “friends with benefits”), including those few (most often young men) who 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, just 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-hydroxybutrate);

(4) **Developmental Immaturity of the Respondents:** The vast majority of undergraduate men are in the age range of 18 to 21; they 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 having sex, can be a 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 hesitation 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 – adolescents. Although typically more mature than the men, they, nevertheless, tend to be naïve and trusting. College men do not raise instinctive red flags of a threat; they are just kids out for a good time (most are). The women too are away from home for the first time and just out looking for a good time themselves;

(7) **The Setting:** The campus, moreover, is seen as a safe, protected environment, free of all the dangerous trouble-makers found elsewhere. This perceived sense of ‘immunity’ is coupled with the impression that *since everyone is doing “it” (partying), it can’t be wrong or risky.*
STARRSA Treatment Program Overview

STARRSA was developed for college students found responsible for sexual misconduct. 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. To the best of our knowledge, STARRSA is the first empirically-based program for the psychological treatment of this college student population. 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 program was intentionally developed to allow for maximum flexibility in order to accommodate the broad range of sexual misconduct behaviors encountered on college campuses. Research devoted to heterosexual women and members of the LGBTQ community that sexually abuse others is quite limited. Using all of the resources available to us, we have nevertheless attempted to offer guidance for clinicians that are working with such students and are using our program.

The core of the STARRSA program is set forth in this Treatment Manual. It is designed to facilitate high quality assessments and treatment interventions. It is designed to help guide qualified clinicians who are relatively new to treating students found responsible for campus sexual misconduct, as well as providing many useful resources for those with more experience as well.

Clinicians that use this program should be familiar with the clinical and empirical literature addressing campus sexual assault. This includes consideration of three fundamental features that are embedded in this program to increase effectiveness and maximize usefulness while maintaining an empirically based, comprehensive, cohesive approach to treatment.

The first feature utilizes known population characteristics to help facilitate treatment. This population (i.e., college students) constitutes what Arnett termed “emerging adulthood” (Arnett, 2000). College students are at a developmental stage not far beyond adolescence which is characterized chiefly by a newfound independence (often living independently away from home for the first time and subject to the whims, desires, and pressure of peers), a freedom to engage in social/recreational pleasures (partying, dating, “hooking up”) without parental oversight, immature problem-solving and decision-making that is exacerbated by peer pressure and disinhibited by alcohol, and risk-inadversity.

These factors, however, must be considered in the context of how students enter treatment. That is, how they will likely experience and respond to a recommendation that they engage in treatment before resuming their studies. It is highly unlikely that most students will be entering treatment of their own volition. The challenges to treatment engagement and motivation are similar to those found in other treatment-
mandated populations (e.g., criminal justice) and motivation and willingness to engage in treatment may need to be addressed throughout the program. By incorporating a motivational interviewing approach throughout the program, we can meet students at their developmental stage (e.g., their “hedonism,” impulsivity, lack of clear realistic life goals and direction), explore ambivalence, roll with resistance, and enhance motivation.

Although these students are typically referred to STARRSA by their schools, and their schools will likely require feedback regarding treatment progress, STARRSA is designed as a therapeutic intervention and therefore, the students are treated and referred to as therapy “clients” with the rights and privileges accorded to therapy clients in the context of a therapeutic relationship. By referring to students as clients, we underscore the need to treat them with the respect we afford other clients, rather than overfocusing on their “status” as students mandated to treatment because of sexual misconduct.

The second feature includes consideration of the unique, empirically supported risk factors associated with campus sexual misconduct, such as certain attitudes and beliefs about sexuality and relationships, peer pressure, and the disinhibiting effects of alcohol. As such, STARRSA follows an RNR (Risk-Needs-Responsivity) model, herein treatment begins with assessment of needs and is tailored to a student’s unique needs as determined by identified risk and protective factors and treatment response considerations (e.g., motivation for change, learning style, and gender and sexual identity or orientation). As much as possible, this treatment approach relies on empirically supported interventions to target relevant risk and protective factors and risky behaviors. 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 for the clinician is to select, based on the Module 1 intake and assessment, those modules or sessions within modules that are most appropriate for the individual’s needs.

The third feature combines the generational preference of communication and learning through media technology, with the responsivity element of RNR. To that end, we provide many optional resources that the clinician may choose from if considered appropriate for a particular client (e.g., YouTube, Ted Talks, and videos made specifically for this program), as well as PowerPoint presentations, experiential exercises, and out-of-session assignments. These resources are intended to increase client engagement and facilitate change in a relatively brief amount of time (the entire program is estimated to be no more than 30 one-hour sessions, or possibly less depending on treatment needs). Consideration of these features should enable colleges and clinicians to use STARRSA on and off site to treat a wide range of sexual misconduct behaviors.

Mission

This treatment program utilizes a multi-faceted, multi-modal, empirically-based approach to risk and needs assessment and treatment of students who have engaged in sexual misconduct or assault. 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.

**Program Philosophy in Capsule Summary**

This program is rooted in the basic belief that the vast majority of college students are good kids still very much in the throes of adolescence; a stage of development well known to be characterized by social, emotional, and cognitive immaturity and poor decision-making. Adolescents are also drawn to hooking up and socializing and are highly impressionable. All of these characteristics are exaggerated by alcohol. Far from being immutable, their sexual misconduct can be highly responsive to effective interventions that reduce risky decisions and promote safe, prosocial behavior in intimate relationships.
Program Participants & Client Diversity

STARRSA was designed for college age students, in the age range of 18 to 25, who have been found responsible by their academic institution for perpetrating sexual misconduct. The term misconduct covers a wide range of behaviors, as noted above, from non-contact unwanted sexual behaviors (e.g., sexually harassing gestures and language, sexual pressure, stalking, unwanted touching) to legally-defined rape. STARRSA was designed to accommodate the needs of all students, integrating multicultural identities into the STARRSA language and clinical protocol.

The students referred for treatment typically have not been adjudicated for sexual misconduct. Although they may or may not be represented by an attorney, the process of engaging in treatment must not end up being a backdoor to self-incrimination. A corollary of treatment must not be an abrogation of the 5th Amendment right against self-incrimination. Clinicians are not fact finders and should not require the students to discuss details of the sexual misconduct beyond what was reported by the complainant. Instead, clinicians should focus on those risk factors that were most closely associated with the student’s sexual misconduct. The goal is promoting health, not building a legal case.

Client Diversity

Student Diversity: Considering the different layers of social and personal identities of our clients

Students come from a range of different backgrounds and cultures. The STARRSA program is intended to be inclusive of and used with all students, across the range of different social and personal identities (e.g., ethnic, racial, religious, gender, and sexual orientation). 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 to be used with students of different gender and sexual orientations. We are available for consultation throughout the pilot period to address questions related to adaptations and applications and want feedback about your experiences with the application of materials to various students.

We want to underscore that by using an RNR (Risk-Needs-Responsivity) framework, the clinician can take empirically derived risk and treatment factors and apply them to an individual. Our program emphasizes a tailored, individualized approach to treatment that includes considering the various relevant identities and social arenas within which a student operates. We recommend that clinicians consider the various aspects that fall under the broad umbrella of social and personal identity because these impact the student’s opinion of self, others, and their world view, as well as their attitudes and behaviors. Identity can include racial and ethnic background, immigration status, gender, sexual orientation, religious affiliation, as well as political, 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 of flexibility across different identities (e.g., a student may have a crystallized political identity, but a fluid gender identity).

**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 identity, 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 clinician 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 facing these issues may be at increased risk of harm to self or others. If a clinician 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 by peers. Given that college students are peer-oriented, we include “identities” that are commonly seen on college campuses, such as fraternities and athletics. In the section below we discuss specific social and personal identities, relevant to college students, and underscore that this list by no means is comprehensive. We have included relevant peer groups and organizations that are normative for this age group, but are also either relevant for their association with risk factors, such as parties with alcohol consumption, or because of perceptions about this association. A student may identify with multiple groups from this list, and within each category, there may be “variations” or “subcategories” unique to that student. For each social and personal 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 is not meant to provide a comprehensive training for different identities, but provide a basic foundation. We recommend that clinicians seek additional information and consultation about a particular identity if it appears to be treatment-relevant and if they have limited knowledge and/or experience working with that identity.

2) present general key issues, challenges and concerns often expressed by members of this group. This does not mean that a student who is a member of that
group will have the same concerns, only that they are commonly noted concerns and should be considered. This includes suggestions to consider for clinicians when working with students to help enhance rapport.

3) A summary of the literature on this population in context to sexual misconduct.

**Cautionary Note.** We want to provide some cautionary points about social and personal identities. Although we encourage clinicians to explore and consider the different facets of a student’s identity, it is all too easy to become overly focused on one particularly aspect of their identity and/or lose focus of the goal of this treatment, targeting factors related to the student’s sexual misconduct. A danger of classifying a student by their identity is that it can divert the clinical 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. In this program, a proper treatment plan must target the treatment needs related to those risk factors that are thought to be most responsible for the misconduct.

**Race and Ethnicity**

Race is a social construct that Helms and colleagues (2005) argued lacks “consensual theoretical or scientific meaning in psychology,” and cautioned about using race as a variable in psychological research. With respect to identity, however, race and ethnicity can be quite relevant and meaningful. A clinician 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 in treatment. For instance, 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 treatment may have contributed to their misconduct. Moreover, how these experiences are 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 clinician 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.

With respect to utilizing campus counseling services, results vary. 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), whereas another study found that, among Asian, African American/Black, Latino/Hispanic, and Caucasian/White students, there was no difference in rates of utilization of counseling services (Rosenthal & Wilson, 2008). These relationships appear more complex and undoubtedly reflect considerably variability across campuses. Among African-Americans students, those 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 reduce likelihood of seeking help among African American students (mostly women) (Masuda, Anderson, & Edmonds,
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).

**Religious Affiliation**

Many campuses have clergy representing only the major (monotheistic, western) religious dominations in the United States (Catholicism, Judaism, Protestantism, Islam). Clearly, this represents but a small fraction of the religious denominations throughout the world. If a student belongs to a denomination for which there is no campus representation (clergy or student groups / clubs), this might impact their perception of inclusion, especially if they are devout adherents. In addition, belief systems tied to religious faith may have some bearing on treatment and may have to be addressed (i.e., the beliefs that these students hold may not be consistent with therapeutic aims, and may have to be addressed).

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 out how religious and ethical beliefs and practices impact attitudes and beliefs about sexual misconduct in students found responsible.

**Women and Sexual Misconduct Perpetration**

Overall, there has been very little empirical research on female sexual offenders, and none on women who engage 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 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, as well as digital penetration or penetration with an object. The limited research on 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 fairly recent and detailed literature review of female sexual offending.
The limited information and research 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 thought that criminal justice and other professionals may discount sexual abuse by woman, considering it perceived 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. Yet, women and men who are the targets of sexual misconduct by females can and do experience significant trauma as a result of this victimization and negative effects may ensue and persist.

The literature does suggest some important findings relevant for 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 of 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.

**Gender and Sexual Orientation**

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 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 uses 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.Transstorah.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 effect 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; they 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 him / her to begin to separate their behavior from their sexual and/or gender identity.

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, all of the topics associated with Lesbian, Gay, Bisexual, Transgender, or Queer or Questioning (LGBTQ) are fluid, meaning that they are often changing and the client will likely be somewhat confused (albeit less confused than you). Be sure to ask questions about matters or concerns that you are not familiar with or do not understand. The clients are the experts of their own experiences.

With respect to body language, be mindful of your seated position. For instance, do not shift in your chair or cross arms or legs as the client discusses the fluidity of sexuality or gender. Many of these topics might be out of your comfort zone, but that does not make us less of a clinician. 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 who work with LGBTQ clients. As per the guidelines, clinicians are urged to understand that societal stigmatization, prejudice, and discrimination can be sources of stress and create concerns about personal security for LGBTQ clients. Clinicians are also encouraged to avoid attributing a client’s non-heterosexual orientation to arrested psychosocial development or psychopathology. Clinicians 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 are encouraged to recognize how their attitudes and knowledge about LGBTQ issues may be relevant to assessment and treatment, and seek consultation or make appropriate referrals when indicated. Clinicians should strive to distinguish issues of sexual orientation from those of gender identity when working with LGBTQ clients. Clinicians must recognize that the families of these clients may include people who are not legally or biologically related. Clinicians are encouraged to explore with their clients any issues and concerns related to their family of origin and extended family. Clinicians 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 LGBTQ child. Clinicians 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 in the LGBTQ population do not necessarily vary from other psychiatric populations. That is, any clinical signs that are known (e.g., difficulties sleeping, hopelessness, loss of interest, racing thoughts, etc.) are the same with LGBTQ or their 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 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 LGBT 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 (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.

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 LGBQ 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-LGBT 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, LGBT 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 LGBQ students and heterosexual students experienced similar rates of forced sexual contact and forced sexual intercourse, but the LGBQ 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 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

Greek life can represent a significant part of a student’s college experience. Although the camaraderie and peer bonding associated with Greek life can have many benefits, the associated partying, TGIFs, soirees, and social gatherings has become a significant vehicle for promoting sexual assault through a confluence of several individual risk factors: (a) a few “alpha” males that hold attitudes consistent with negative masculinity, including sexual entitlement and sexual “conquest,” (b) ample presence of alcohol that efficiently lowers inhibitions against sexual assault, and (c) a large number of members of the fraternity that are more than willing to “have fun” and go along for the ride. 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 alcohol use mediates the relationship between membership in a fraternity and sexual aggression. Martin and Hummer (1989) studied the group and organizational practices and conditions that encourage abusive social settings.
for women in fraternities. 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). Koss and Gaines (1993) found, however, that fraternity affiliation did not contribute to the prediction of sexual aggression. Schwartz and Nogrady (1996) found that there is male peer support for victimization of women, and that it is linked to extensive alcohol use. Schwartz and Nogrady (1996) reported, however, 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. 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. In a study by Nurius, Norris, Dimeff, and Graham (1996) the majority of fraternity men indicated that they 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 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. These latter finding would seem to underscore the realistic, “real” risk posed those men who are in the best position to estimate the risk.

Athletes

Similar to what was stated above regarding fraternity members, high school, collegiate and professional athletes appear to present disproportionately with a confluence of risk factors for sexual assault, primarily attitudes consistent with negative masculinity, including sexual entitlement and sexual “conquest.” Athletes, certainly those at the higher end of widely-followed competition in the mass media, most obviously football, are generally viewed as the “icons” of masculinity, veritable symbols of what it means to be “a man.” 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 “superjocks.” Adoration can bring both narcissism and a sense of impunity. Sexual entitlement comes with the territory. Sex is a privilege that comes with your status, a license to have sex with anyone you want. When sex becomes your prerogative, mutuality may cease to exist. It is no longer a union, as “hookup” implies; it is an alpha male getting what is rightfully his. 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.
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 that dictates 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; 3) 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.

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 often times, 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. This is particularly important when the student reintegrates fully to campus activities after completing their sanction. Coaches can be instrumental 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. 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).

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 that when present in moderation can be highly effective skills outside of sports. The clinician 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 embrace negative and dangerous 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 (e.g., captain). If they are in a team leadership position or have a higher standing or status, the clinician could work with them about what this means as a role model for other teammates and how they can effect positive change within 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, additional consideration and 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 team mates that he has to worry about but the entire college community – and conceivably beyond.

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 22.6% of the perpetrators of sexual assault, 13.6% of perpetrators of attempted sexual assault, and 13.6% of perpetrators of sexual abuse as student athletes. 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.

Rape is generally viewed as an act against women, as such, male rape is frequently not discussed in education and prevention programs (Scarce, 1997). However, in a study utilizing 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.

Foubert and Perry (2007) 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 of fraternity members to survivors of sexual assault in general. The program was further found to decrease rape myth acceptance, and the likelihood of committing sexual assault in this sample (Foubert, 2000; Foubert & Newberry, 2006). However, there was no change in sexually coercive behavior (Foubert, 2000).

**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). Beyond these common reactions, however, students may bring other strong emotions stemming from their life experiences, including their own abuse. 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).
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. Sex can be a lot of fun and feel good for both people, but only when both people want it, and it is fully consentual. Only then is it fun. Guys must 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 her 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. When an adult “steals” sex, it is demeaning to him in a similar way; it says he can’t get sex 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, such as those that present as narcissistic and/or with other psychopathic traits (e.g., conning, manipulative, deceptive, lying), 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 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. If indicated, document your observations in progress notes.
Clinician Qualifications

We recommend that clinicians have a minimum of a Master’s degree in counseling, or related field, and be independently licensed mental health professionals with training in cognitive behavioral therapy (CBT). We further recommend clinicians have training in working with clients mandated to participate in treatment. Graduate students in training, or conditionally licensed clinicians, may be considered as long as they have appropriate supervision.

Two specific issues that may arise include (a) working with clients (students) that have not sought out treatment, are not motivated to be in treatment, and may, at least initially, be highly resistant to treatment, and (b) clinician gender. Although the gender of the clinician may occasionally be of issue for some clients regardless of the Module, we only discuss gender as a potential issue with Module 5 (hostile masculinity). To be clear, we do not consider clinician gender an insurmountable obstacle to treatment; qualified clinicians may be few in number and gender choice may not be an option. In Module 5 we are simply highlighting an issue that may need to be addressed.

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.
- Reach treatment goals.

Treatment Approach

Treatment begins with a clinical risk and needs assessment that guides the cognitive-behavioral treatment intervention. Initial and periodic re-assessment will help the clinician in determining the amount of time and focus needed for each domain (Module). The duration of treatment will depend on assessed risks and needs and may involve approximately thirty 50-minute sessions. The number, frequency and length of the sessions are based on treatment needs and the clinician’s professional judgment.

Referrals

On occasion, a referral may be recommended. Referrals would be for risk relevant concerns or problems that require a deeper breadth of coverage than this program is
designed to provide, such as treatment for a long-standing or more severe substance abuse problem, issues related to identity and treatment for specific mental health disorders.

**Components of the Treatment Program**

- The treatment manual includes:
  - Assessment materials: RNI-TV, Brief Assessment and Interview Guide
  - Document that links the RNI-TV items to specific treatment modules
  - Informed Consent template
  - Treatment Completion Summary Template Form
  - A guide 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:
  - The treatment manual
  - RNI-TV digital version
  - STARRSA Videos
  - Electronic versions of materials (e.g., CERTS hand out, informed consent sample, etc.)
  - A PDF file of the in person training
  - A supplemental training video
  - A pdf copy of the privacy certificate issued by the DOJ

*hard copies of various materials are provided for the pilot.*

**Manual 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 – Informed Consent Packet


Appendix C – Risk Needs Inventory - Test Version
- Risk Needs Inventory Test Version Face Sheet
- Risk Needs Inventory Test Version Manual
- Brief Assessment and Interview Guide for the RNI-TV

Appendix D – 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
    - How 7 Things That Have Nothing to do With Rapt Perfectly Illustrate the Concept of Consent

- PowerPoints
  - Sex and the Law
  - Changing Times
  - Drugs and Rape
  - Groupthink
  - Negative Masculinity
  - Socio-cultural Context of Rape (Rape Culture and Rape Attitudes)

- Multimedia Resources
o All Program Videos by Treatment Modules
o 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.**
o Additional multimedia resources

Appendix E – Sample Treatment Completion Summary
Appendix F – Adjunctive Treatment Interventions
Appendix G – Sexual Misconduct Contributing Factors Checklist (CFC)
Appendix H – Resources for Service Providers
  - Factsheets
  - Organizational websites
  - Guidelines

Glossary (TBA)
Bibliography
Preliminary Preparation: Obtaining Relevant and Necessary Information

Parameters of Confidentiality

Prior to the first session, clinicians need to 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 progress 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.

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, 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 university expectations of feedback versus the student’s expectations of 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, this is not formally an evaluation and not forensic when the student has not been adjudicated. This is formally treatment, and as such, the client is the student. The context, however, dictates that confidentiality is partial (i.e., feedback about the course of treatment will be shared with student conduct officers and such feedback may be determinative in allowing the student to return to campus).
Information about the Client
Clinicians should obtain as much information as possible about the sexual misconduct behavior prior to the first session. The school should provide clinicians with all available information about incidents of sexual misconduct, including testimony from the complainant, the respondent, and a copy of the Contributing Factor Checklist (CFC).

During the first session, the client should be encouraged to view treatment as an opportunity to learn and grow, rather than as a form of punishment. Mild resistance to outright hostility would not be unexpected. Recognizing the anger, permitting its expression, and discussing it will begin to take the edge off. Pointing out that the client is not the only one that was “hurt” by what happened keeps the purpose of treatment in focus.

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.

Treatment Assessment
The initial assessment is intended to determine which risk factors are most importantly associated with the misconduct and what interventions will be required to mitigate those risk factors.

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. This program includes a semi-structured intake interview to obtain relevant psychosocial history, diagnostic information, and identify risk and protective factors that warrant intervention. The included interview provides an in-depth assessment of the client’s dynamic risk factors (i.e., those risk factors which can be changed) to help with treatment planning. The use of this interview is elective. The clinician may wish to conduct her/his own intake interview.

Orientation 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 the parameters of communication between the clinician and the university.
Assessment and Treatment Planning
The initial treatment assessment 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. By using a continuous risk and needs assessment process, the clinician will be able to design, and re-design, an individually tailored therapeutic intervention program delivered in a manner that facilitates a positive treatment response.

Progress and Treatment Completion Assessments
Ongoing interventions are most effective when informed by re-assessments that evaluate the extent to which the interventions have been successful, and what modifications, if any, are needed. To facilitate this, the treatment program recommends quarterly progress assessments to evaluate and update risk factors and treatment needs.

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 should be shared with client and passed along to the school. If the clinician concludes that the client has not satisfactorily completed treatment, this must be shared in writing with the client and with the school, along with clinical recommendations regarding treatment needs.

Potential Treatment Assessment Sources of Information
- 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) –TV and clinical risk and needs interview.

Treatment Planning
Once the initial Treatment Assessment is complete, findings are reviewed with the client and treatment recommendations will be discussed. It is recommended that the client be invited to contribute ideas to the treatment plan. Motivational enhancement strategies will hopefully facilitate and enhance the therapeutic relationship. Although session frequency will vary depending on client need, the STARRSA Treatment Program is geared to approximately 15-30 weeks depending on risk and needs. At the completion of this program, clients will be assessed to determine additional treatment needs, if any. If additional treatment is required, a new treatment plan should be developed.

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, 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
- Medication

**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 done out-of-session assignments. Treatment plans should be updated quarterly or more frequently if indicated by significant life events or changes.
Module 1: 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 its limits, what information 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 part of a pilot program to provide universities with treatment options for students found responsible for sexual misconduct. Make clear that no identifying information will be disclosed to anyone involved with this pilot program.
  - Discuss the limits of confidentiality, including the therapist’s agreement to share treatment progress and completion reports (or whatever was agreed upon). If known, inform the student how these reports may be shared and stored and who will have access to them.
  - 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’s communications with the school should be in writing and reviewed with the student.
  - The therapist should emphasize that no information will be released without prior review with the student.
  - Therapist’s policies about cancellations, tardiness, no shows and fees may be briefly discussed and a treatment contract reviewed.
Orient the student to the therapy program:
- Expectations – clinician, client, and institution.
- Expectations of the student and goals of therapy: why are you here?
  - Reminder about the limits of confidentiality

Complete Risk and Needs Inventory:
- After preliminary information is covered and consent is signed, transition to the Risk and Needs Assessment (Appendix C).
- Add other tests, scales or measures as indicated.

Possible Activities: None specific
- The focus should be to establish the therapeutic relationship, providing and ensuring informed consent, and starting the initial interview assessment.
- Use of scaled/ruler questions to access motivation and confidence. 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, lifestyles?)
- Exceptions: If the client consents to treatment but is not forthcoming or providing terse answers, the clinician may want to ask the client about this. The clinician may need 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.

Therapist might suggest that the client identify any areas or issues that he/she is reluctant to talk about or uncomfortable talking about.

Therapist should reinforce that honesty is vital and that the therapist's job is to help the student not judge the student.

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 of 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.
  - General questions to help develop a treatment plan.
**Supplies/Handouts:**
- Informed consent agreement (2 copies)
- Therapist’s contact information and policies (if in writing)
- Possibly HIPPA guidelines
- Signed Release form if needed

**Session 2: Continued Intake Assessment**

**Check In:**
- Briefly check in about client’s week.
- Briefly ask about thoughts, questions, and concerns regarding the last session.

**Session Goals:**
- Complete the intake assessment (the RNI-TV may be completed with the client or following the assessment by the clinician for subsequent review with the client).
- Evaluate the client’s treatment motivation and level of understanding about sexual misconduct.
- Elicit client’s questions and concerns about treatment.

**Suggested Session Content:**
- Complete intake assessment.
- Assess and encourage motivation to examine behavior related to misconduct.

**Possible Activities:**
- Complete the RNI-TV 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.

**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

Session 1: Sexual Behavior & Sexual Misconduct: How They Differ

Check In:
- 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 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.
- 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.

Suggested Session Content:
- Discuss assessment findings, including the RNI-TV, 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 is 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 freely agree and disagree).

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 2 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 sex.

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 D.

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 D 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-TV
• 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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.

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, e.g., agreeing to a contract or consenting to date or to marry.
- Consent and sexual behavior
  - It’s not just about physical force and violence.
    - Age matters (legal age, varies by state and federal law)
    - Ability to consent (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 Safety¹, 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/). The CERTS Handout and cards included in the pilot materials. An electronic version is on the flash drive.

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

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 D, 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 D 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?
  - What is something new that you learned today or that stood out? How may this be helpful to you in your life?

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

**Check In:**
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

**Session Goals:**
- Increase the client’s awareness that all types of sexual misconduct are offensive and very serious legal consequences can result.

**Session Objectives:**
- Become aware of state and federal laws governing sexual behavior.
- Become aware of potential legal (criminal and civil) consequences for sexual misconduct.
- Become aware of rules governing Registration as a “Sex Offender”.
- Further develop understanding of school policies regarding offensive and abusive sexual behavior.

**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. Thus, having sexual contact with an under-aged college student, even one who agrees and is willing, may be a sexual offense.
  - 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 offensive and abusive sexual behavior.
- Review possible consequences of offensive and abusive sexual behavior.
  - 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 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 D.

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 issues, 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). Some clients may provide examples of the negative effects of sexual misconduct and assault on victims; although this awareness may be very positive, it is not intended to be part of the assignment at this point in therapy.
- Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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: 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.
- Computer, paper and writing implement, or white board and markers for written activities.
Module 3: Focus on Socialization & Sexualization in Society

Session 1: Gender Socialization & Sex

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 lesbian, gay, bisexual, and transgender individuals.
- 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.

Suggested Session Content:
- Discuss what it means to be a “real man” or “real woman.” Explore stereotypes.
- 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 s/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 D.

**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 D). 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 and exercises, and activities outlined in Appendix D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 he/she 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.

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
  o 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
  o Approximately 15-20% of college women report experiencing rape or attempted rape during college and over 50% describe some type of unwanted sexual touching (although 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. Men also are victims of sexual misconduct, although not as often as women.4
  o 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 delinquency5. There is limited research regarding women who engage in sexual misconduct. 6
  o 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 (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 D.

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 the many sexually ignorant, derogatory and demeaning remarks made by public figures and others to discuss next week.

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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).
6 See Program Participants Section for a brief review pertaining to women who engage in sexual misconduct.
7 Abbey & McAuslan (2004)
• Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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 learned today? How may this information be helpful in your life?
  • Is there anything else that you would like to know more about?
➢ Introduce next week’s topic.

**Supplies/Handouts:**

• Computer, paper and writing implement, or white board and markers for written activities.
**Session 3: Peer Influences**

**Check In:**
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

**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.

**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' perception 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 peers consider sexual abuse 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.

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\(^8\) Darley & Latané (1968).

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.
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 D.

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.
  - 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 D).

- 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 their behavior, what s/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 him/her.

- 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, comradesy, 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 that s/he has an obligation that requires him/her to be elsewhere) and begin to address the emotions that contributed to the decision to participate in the misconduct.

- Utilize relevant handouts, STARRRSA videos, or other resources as described in Appendix D.

Possible Out-of-Session Assignments (OSAs):

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

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\(^9\) Janis (1982).
• 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 D 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 D 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

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 1: Risky Attitudes

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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

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 that support respectful relationships.
- Introduce understanding of commonly held erroneous beliefs about how sexually permissive / active other students are.
- Discuss coercive and aggressive sexual fantasies and/or antisocial attitudes, peers, and behavior, if assessment findings suggest these may be present.

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 D.

**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 his/her 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. Remind clients with rape supportive attitudes and beliefs that most men/women do not share these views. This 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 s/he chose not to act in such a manner.
- Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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.

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 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 s/he 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, ask him/her to write them down and share the ones that s/he feels comfortable enough to share.
- Encourage the client to identify those feelings that feel good and are positive, those that do not feel good, as well as those that may be risky and negative and 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 D.

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.
● Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 that may have been, were, or could be related to sexual misconduct.
- Consider various strategies that may help the client manage these behaviors effectively.
- Begin developing effective intervention skills.

Suggested Session Content:
- Consider 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) and rule breaking and antisocial behavior.
- Provide information on casual sex, “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.

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

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.

Possible Activities:
- Help the client identify risky and negative behaviors s/he 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 consider nonsexual rules or law breaking behaviors first (e.g., taking something that didn’t belong to him/her) and then transition to how attitudes and beliefs that supported those behaviors may be related to engaging in sexual misconduct (e.g., “It is okay to look out for myself and take what I need. Others look out for themselves too.”).
- 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. Identify sexual arousal (or other risk indicators) and desire to act;
  2. Chill 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. Evaluate options and decide what to do;
  4. Do what I have thought through and evaluate my choice.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix D.
Possible Out-of-Session Assignments (OSAs):
- Encourage the client to practice (and log) emotion regulation skills, at least once a day.
- Instruct client to practice problem solving skills in multiple settings by using strategies such as the “ICED” technique described above.
- Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Discuss last week’s assigned Out-of-Session Assignments (OSAs).

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.

Suggested Session Content:
- Review how risky thoughts, feelings, and behaviors can contribute to risky situations, e.g.,
  - Party 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 risky situations for him/herself 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 drew him/her back? If it was as good as remembered, but risky, brainstorm with the client 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 s/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 D.

Possible Out-of-Session Assignments (OSAs):

- Ask the client to watch a video or read information that depicts a campus rape culture (See resources and provide examples, e.g., Locker Room, 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.
- Have the client write a written essay 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 D 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**

**Check In:**
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

**Session Goals:**
- The immediate previous sessions have focused on identifying risky 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 environments and situations where substance abuse is encouraged or facilitated.

**Session Objectives:**
- Help the client to identify environments, situations, and other stimuli 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.

**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.
  - Other “date rape” drugs, such as Rohypnol (roaches, rochas, roofies).
  - 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.
- 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?
  - How does substance use affect ability to get consent?
  - How do substances affect the level of sexual pleasure?
  - 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 their 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 their 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 they “get” from it)? What are the negatives? What are alternatives?

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

- Have the client think of a specific situation (sexual or non-sexual) where she/he and others were drinking or using substances. 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 they 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 environments, situations, and peers that encourage, facilitate, or stimulate the client to want to engage in risky substance use behavior. Examples might be 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 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 D.
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 s/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 D 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 (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 ego syntonic. 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?

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session/assessment.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 (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).

**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.

**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.
- 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.

**Suggested Session Content / Possible Activities:**

- 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 D.

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.
  o PowerPoint presentation of quotes of politicians about women.
  o 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.
  o Have the client complete one of the many scales on stereotypic characteristics of hyper-masculine men and discuss which he identifies with.
  o 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=VVzy6gsCqnE
    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 D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Briefly discuss last week's assigned Out-of-Session Assignments (OSAs).

Introduction to the Session
- 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.

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.

Session 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.

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 D.

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:

iv. Male athletes against violence:  https://www.youtube.com/watch?v=I7UAtd2h88
v. Cadets against violence:  www.youtube.com/watch?v=VYzy6gsCqnE
vi. 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 D 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 multinational 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.
- This is perhaps the most powerful technique because it melts the dis-similarities between men and women; the greater the perceived similarities and the fewer the perceived differences, the more women become like “bros.” In the assignment illustrated above – or the equivalent “assignment” done in a therapy session – the
goal is to dimensionalize cardinal traits that define what it is to be a cool guy, a successful guy, an admired guy, and point out “guys” actually fall all along a continuum with respect to those traits – and – amazingly, so do women.

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=umKKrbdmdHFM -- “The Mask of Masculinity”
  - Wade Davis
  https://www.youtube.com/watch?v=jVI1Xutc_Ws -- “Be a Man” - Joe Ehrmann

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

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 6: 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 his/her behavior. As such, the session may become emotional as the client recognizes and feels an array of emotions related to the harm s/he 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 can 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 pathology, or perhaps another psychological impairment that impacts their ability to take others’ perspectives or empathize with them, she/he 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 she/he may need additional support and help developing additional coping strategies. 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

Session Goals:
- Help client develop an understanding of the impact sexual misconduct and abuse has 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 multiple 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.

Suggested Session Content:
- Explore the impact of sexual misconduct on the victim/survivor from multiple perspectives –psychological, social, financial, etc.
- Discuss 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 on victim/survivors. 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
  - See Appendix D for additional options
- Select one or more victim impact vignette for discussion and exploration. (Victim Impact Vignettes are located in Appendix D).
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix D.

Possible Out-of-Session Assignments (OSAs):
- Ask client to log his/her thoughts/feelings about today’s session and the potential effects of sexual misconduct.
- Have client write a list of all possible consequences for the survivor in the video watched during session (shown and not shown) and how others may have been affected as well.
- Consider asking client to watch some of the 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
  - 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)

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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://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf)

Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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.
- If there are indications of a lack of remorse or that the client is only concerned or feeling bad about the fact that they were found responsible, additional interventions that attempt to elicit at least a cognitive appreciation of harm done and remorse 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://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf)
Session 2: Effects of Sexual Misconduct on Victim/Survivors and Others

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 of the sexual misconduct. Facilitate an increased understanding and empathy for the complainant (the client’s victim/survivor) 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 victim/survivors. The ripple effects of sexual abuse on others.

Session Objectives:
- Enhance the client’s perspective taking, level of empathy, and remorse for all victim/survivors of sexual misconduct and address any problems with such.
- Facilitate awareness of and empathy to others harmed by sexual misconduct, in addition to victim/survivors.
- Develop an understanding of the consequences of sexual misconduct to the people responsible for such behavior.
- Develop an understanding of how the client’s behavior and the ramifications thereof have impacted the client’s life in the short and long term.

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 victim/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 and, specifically, for the complainant.
- Help the client appreciate the impact or possible impact of the sexual misconduct on his/her complainant (the client’s victim/survivor).
- 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.
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, guilt
  - 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 abuse impacts those responsible. Discuss the potential immediate, short and long term effects. Ask the client to discuss how sexual abuse and/or sexual abuse 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 his/her sexual misconduct and support the client’s expressions of remorse, regret, and concerns about repeating the behavior.
  - Discuss with the client how this situation has specifically impacted his/her life. Explore the impact across various areas of life.
  - Question if there have been any retaliatory effects from the victim, friends, etc.
  - If people do not know about the abuse, does she/he have any concerns about how others’ would react if they found this out about his/her behavior?
  - Encourage the client to begin thinking about how s/he would like to prevent sexual misconduct in his/her own life as well as to help others.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix D.

Possible Out-of-Session Assignments (OSAs):

- Instruct client to create a list of all people harmed by the client’s 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).
- Have the client write statements expressing amends. As noted above, the client should NOT use names or identifiers, or contact the victim/survivor. The purpose of
this exercise is for them to increase their understanding of harm done and express their feelings about his/her behavior. The statements should be brought to therapy only. The client is not required to describe the offending behaviors to complete this assignment.

- Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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 the following:
  - How was this session compared to last week
  - Ask the client to identify and discuss his/her emotions that were evoked during this module.
  - Ask the client what the most emotionally evocative part of the session was and why s/he thinks 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.
Module 7: Behavior is a Choice: Choosing Wisely

Session 1: The ABCs of Human Behavior

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 they have made.
- Discuss how emotional states and thoughts affect behavior.
- Build effective decision-making skills.

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. 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 been engaging 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 the number of factors that affect choice/decision making. They include some of the following: a person’s past experiences, their past choices (have they had positive or negative outcomes), 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:
- 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 in session 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 D.

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 D 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 2: My Values and Goals: Who I Am and Who I Want to Be

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 s/he can get back on track.

Session Objectives:
- Help the client define values and goals.
  - Goals of treatment – review what they wanted to get out of treatment, and what else can they get out of treatment that would be helpful to their psychosocial development.
  - Goals for when they return to school.
  - 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 their 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.

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 make a contribution 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.
- Have client identify long terms life goals – what do they want from life, what do they envision?
  - Does this include a partner, children, and friends?
- What are the things they value, what type of person do they aspire to be?
- Does their 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, STARRRSA videos, or other resources as described in Appendix D.

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

- Have the client draft a values, goals, and objective statement that demonstrates how s/he wants to live his/her life (especially regarding his/her relationships with peers, friends, family, fellow students, and co-workers) and how they 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 they can use their 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 D 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 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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

Session Objectives:
- Help the client identify his/her emotions, thoughts, and circumstances that lead to maladaptive behaviors and his/her sexual misconduct.
- Help the client identify, develop, and enhance skills to effectively manage risky thoughts, feelings, behaviors, and situations.

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 they 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 they 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 they 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, have
they 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 their behavior toward that person.

- Brainstorm with the client specific signs that they 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 s/he is in this program because of thoughts that led to behaviors that resulted in the person 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 their relationships with others and what emotions and thoughts accompanied them. What were the consequences of the choices s/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 D.

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 D 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.
Module 8: Healthy Relationships

Session 1: Friendships and Partners

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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.

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?

Suggested Session Content:
- Review with the client the different types of relationships they have, including relationships with their family members, peers, acquaintances, faculty, and employers.
- Explore relationships that they have had that involved sexual intimacy (including committed relationships, hook-ups, etc.).
- Explore relationships they 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 D.
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.

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 D 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:
  - 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

Session Goals:
- Develop 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.
- Develop/facilitate perspective taking.
- Introduce/facilitate active listening skills.

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 have a practice run.

Possible Activities:
- 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?
- Ask the client to define empathy and request examples of when s/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. 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 D.

Possible Out-of-Session Activities (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 D 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?
- 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session/assessment.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

Session Goal:
- 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.

Suggested Session Content:
- Communication involves fully focusing one’s attention the other person.
- Communication involves not only active listening 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 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:
- 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?
- Feedback on one’s communication skills is imperative. Practice asking for feedback.
- Practice Active Listening skills.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix D.
Possible Out-of-Session Activities (OSAs):

- Have the client practice communication skills in various relationships (e.g., a friend, a boss, etc.) and complete a work sheet that documents:
  - The type of communication skill.
  - For each skill – list the response, whether it was 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 D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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.
- Instill a sense that healthy relationships are ones of equals where compromise occurs.
- The client learns that gender stereotypes are damaging to both males and females.

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 they see themselves as men/women or an alternative gender identity, specifically how do they want to present themselves 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:
- 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 D.
Possible Out-of-Session Activities (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 D 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 her 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.

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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 their values regarding sex and increase their ability to put them into practice.
- The client will be able to describe/discuss their attitudes about past sexual behaviors that they feel were healthy and those that they now feel were not healthy.

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., perspective taking, problem solving, etc.).
- Assist the client in reviewing and implementing the CERTS 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 harm, such as unwanted pregnancy, sexually transmitted infection, and physical injury.

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 they think a potential partner may be interested as well as how they 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 D.

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.
• Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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

Session 1: Accountability and Responsibility

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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

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 student has acted in responsible and accountable behaviors historically, and encourage the client to articulate ways in their life that they have shown accountable and responsible behavior more recently as well (e.g., participating in therapy).
- Have the client articulate ways in which their 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 they could have demonstrated more responsible behavior and how they can do so in the present and future.
- Utilize relevant handouts, STARRSA videos, or other resources as described in Appendix D.

Possible Out-of-Session Assignments (OSAs):
• Have the client keep a daily diary or log of ways in which their behavior during the week was responsible. Ask the client to note any urges to engage in impulsive behavior or actual irresponsible behavior. What were the situations and behaviors? What thoughts and feelings contributed to their behavioral choices?
• Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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

Check In:
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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.

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.
- Discuss ways to make amends and make a difference by helping prevent sexual misconduct on campus and elsewhere.

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 s/he would be willing to share how that felt.
- Ask that the client think about what they learned in Module 6 and the companion videos or treatment assignments and discuss what might it feel like to experience sexual misconduct in college.
- 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 an apology to the victim/survivor (if and only if this is something the victim/survivor wants) and letting the client know that the client, and only the client was 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 ways that could be used against them in later legal proceedings.
- Brainstorm with the client ways s/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.

- 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 D.

Possible Out-of-Session Assignments (OSAs):
- Have the client develop a list of ways that s/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, providing a genuine one for harm done).
- Assign relevant multimedia resources and exercises, and activities outlined in Appendix D 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/survivors. 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 or similar ones:
  - What were some things you found useful about today’s session? What wasn’t helpful?
  - Name something 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.

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.

Supplies/Handouts:
- Computer, paper and writing implement, or white board and markers for written activities.
Module 10: 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-TV) 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, these needs should be documented in the discharge summary and appropriate recommendations and referrals should be made.

(Note: Clinician should be mindful of confidentiality limits and review confidentiality agreement prior to contacting the university. Any contact with the university should be consistent with the client’s consent, including inquiries about possible options and services that may provide additional support for the student and should be done, whenever possible, without disclosing unnecessary client-specific information.)

- This 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. The clinician completes the RNI-TV 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. 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 any apparent risk relevant treatment needs.

- 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, 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.
Session 1: What Have I Learned? Assessment & Feedback

Check In
- Briefly check in about the client’s week.
- Ask about questions, comments, and thoughts and feelings regarding the last session.
- Review last week’s assigned Out-of-Session Assignments (OSAs).

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-TV.
- 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 areas of weaknesses, challenges and improvements, understanding of any current risks or needs as well as protective factors and supports.
- Review and reinforce client’s strengths, newly developed skills, treatment gains, and positive changes.
- Use the RNI-TV to review the client’s current risk and protective factors, and identify any additional or outstanding treatment needs.
- 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, and client’s receptivity to additional services/resources.
- Consider if additional services are needed, and client’s receptivity to such.
- Provide comprehensive feedback about treatment.
- Gather relevant information for the Treatment Summary Report.

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 s/he feels has been achieved in treatment. Allow 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 and plans for exiting risky situations and increasing 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, 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.)

- Review or complete the RNI-TV 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. The clinician should remind the client of the agreement regarding what will be shared with the school at the end of treatment. The client can rescind their permission to disclose specific confidential information, but the clinician will need to inform the school that treatment has not been completed successfully, if this is so.)

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. (See template: My Plan for Success in Appendix D).
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-TV Manual and RNI Face Sheet
Session 2: Plans for Healthy Living: Going forward

Check In:
- Ask about the client’s thoughts, feelings, and/or questions and concerns regarding the last session/assessment.

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 a sample).
- Review client’s plans for going forward.
- Discuss any additional treatment services and needed referrals.

Objectives:
- Finish review of treatment progress and any further treatment needs.
- Discuss the client’s plans for going forward.
- 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 will 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.

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 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.
Appendices
APPENDIX A

- Informed Consent Packet
Components of Informed Consent for Psychotherapy Services

Preliminary preparation for the Informed Consent

Sample Informed Consent Statement
Possible Components of Informed Consent for Psychotherapy Services

1. Nature, purpose and course of treatment including information about treatment effectiveness.
   a. General information about psychotherapy
   b. Specific information about this program – CBT, RNR, session format, OSA
      i. Include information that this is a pilot program sponsored by the SMART Office of the DOJ.

2. Confidentiality and limits
   a. HIPPA, FERPA policy information
   b. Limits of confidentiality including what information will be reported back to the university at the completion of treatment.
   c. Policy about how requests for additional/subsequent information from the university will be handled.

3. Fees and cancelation policies
   a. Please include your cancelation policy (24/48 hours, etc.)
   b. Because this is a government funded pilot program, there is no cost to you. However, only attended sessions are covered, which means that if you do not show for a session or fail to cancel according to the policies outlines, you will be responsible for the fee for the session which is $____.

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 about what information is needed regarding progress and treatment completion.

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. Obviously, institutions will differ in their expectations of what information is minimally adequate.

Anything additional must be considered in the context of what is necessary to demonstrate to the institution evidence of positive “change” or “progress.” Additional requests for information after the Informed Consent was signed must be evaluated in terms of what was originally committed to and discussed with the student before releasing any further information. Importantly, further requested information should not be clinically or therapeutically contraindicated and should only be considered if it is clearly related to the risk of sexual misconduct. General information about compliance, attendance, treatment engagement, and follow through useful to the institution can be provided without disclosing the specific content of sessions. In sum, the therapist must obtain a clear sense of what will be required to be reported and this in turn must be communicated to the student, who can then decide whether or not to accept the school’s conditions regarding the referral for treatment. If the student declines the conditions, the therapist must inform the student he or she will have to contact the school and let them know the student’s decision.
Areas of information that may be released and agreed upon between the institution, the provider and the student:

a. Frequency of communication with institution (e.g., monthly, one time at the completion of treatment). Once at the end is recommended unless there are compliance issues, the student leaves treatment prematurely, or is not appropriate for sexual misconduct-related treatment at the present time, due to other urgent and/or critical clinical needs, such as treatment for acute substance use/abuse, symptoms associated with major mental illness, acute symptoms of depression or anxiety, or threats of violence.

b. How will this information be conveyed? The treatment completion summary is a recommended format.

c. Will any verbal communication between the clinician and school be required? We recommend that such communication be minimal and that the contents of such phone communication must be consistent with the informed consent guidelines about what will be disclosed.

c. What additional, if any, information will be required if the client prematurely leaves treatment or does not complete treatment? It is recommended that the treatment summary document be used.

d. Who at the university will have access to this information?

e. Will all information from the clinician that is submitted to the school become part of the student’s record?

f. Storage of information given to the university: How will this information by protected?

g. Duration of time that this information will be retained?

h. Possible uses in the future, including limits on the use of this information? (This usually occurs: 1) when the institution decides to let the student re-enroll, or 2) in the event of future disciplinary action. Institutions should have clear internal guidelines regarding how this information should be stored and safeguarded.)

i. The clinician should provide information to both the institution and client about how requests for additional information will be handled after treatment has commenced and after the initial informed consent has been obtained. It is recommended that new requests for information made by the institution (i.e., after the parameters of information are agreed upon by all parties - the student client, institution and provider, and the initial informed consent is obtained), be reviewed on a case by case basis. It is recommended that the provider inform the institution that requests for new information be reviewed by the provider, but not guaranteed, and release of additional information be granted if the following conditions are met:

- the information requested is risk relevant
- the information is not clinically contraindicated, e.g., will not undermine treatment progress
- the information is not potentially harmful to the student
- consent is granted by the student
the therapist should determine how the information is to be communicated (e.g., in writing via regular mail or hand-delivered, via email attachment) and the level of detail expected.

The therapist should review the request. If the therapist decides to provide services for the student and meet the conditions stipulated by the university, those conditions must be reviewed with the student, and consent obtained in writing. If consent is not given by the student, this should be conveyed to the institution,

Suggested information submitted to the institution post-treatment via the Treatment Completion Summary:

a. Number of sessions completed (to date or in total if submitted at completion)

b. Attended/ing sessions as scheduled, problems with attendance, no shows

c. Treatment compliance (e.g., effort, motivation, engagement). This can include simple statements about these areas, such as the therapist’s opinion about the student’s level of motivation and engagement and student’s conscientiousness with completion of assigned tasks.

d. General statements about treatment gains. This can include statements about the student’s development of victim perspective, identification of risk and protective factors, and changes in attitudes. Note: The therapist should address these topical areas broadly without divulging any specific content.

e. General statements about possible need for additional support or treatment post sanction or upon the student’s return to the college/university if the student was suspended.
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

The development of this psychotherapy program was funded by an agency of the Department of Justice. The 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]:

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• 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 hours 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 hours 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 B

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.

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<th>Accepting Responsibility for all Sexual Behavior</th>
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### Peer Relationships

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### Module 4: Understanding & Resolving Risks for Sexual Abuse

- Session 1: Risky Attitudes
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- 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

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- 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

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### Intimate Relationships and Sexual Behavior

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### 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
### 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 5: Negative Masculinity

- **Session 2**: Moving from the Abstract to the Personal (Healthy Masculinity)

### Module 10: Wrapping Up & Going Forward

- **Session 2**: Plans for Healthy Living: Going forward

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This Guide is an accompanying product to the STARRSA: Science-Based Treatment, Accountability, and Risk Reduction program, part of an ongoing project (Grant # 2014-AW-BX-K002) funded by the United States Department of Justice, Office of Justice Programs [Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking]. For more information about the project, please contact Principal Investigator Robert Prentky, PhD, at rprentky@fdu.edu or the Co-Principal Investigator Mary Koss, PhD, at mdk@email.arizona.edu.

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APPENDIX C

Risk Needs Inventory Test Version (RNI-TV)

- Risk Needs Inventory Test Version Face Sheet
- Risk Needs Inventory Test Version Manual
- Brief Assessment and Interview Guide for the RNI-TV
SEXUAL MISCONDUCT RISK & NEEDS INVENTORY  FACE SHEET

Name: ____________________________________ Age: ______________

Note: Intake ____  Interim ____ or  Final ____ Dates covered: ___________________

Treatment status: Active _____ Refused ______ Dropped out _______ Completed _____

Number of sessions this period: Offered _____ Completed _____ Refused____

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*Other goals (optional):

Summary of Treatment Needs:

Therapist signature: ___________________________  Date Completed: __________

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Introduction:
This 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. Identified risk domains may indicate treatment needs to be addressed in treatment. Not every risk area will be relevant to a particular individual and some factors indicating the absence of risk may be protective (e.g., the absence of abuse supportive attitudes and beliefs).

The RNI provides a way to summarize 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, as well as maturation. Quarterly rating assessments may provide information about treatment progress relevant to identified 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 facilitate the assessment of relevant risk and protective factors that may warrant intervention in order to reduce the likelihood of future misconduct and promote prosocial behavior. Research validating the RNI’s utility as a treatment planning guide and measure of treatment progress is encouraged.

As presented in the Rating Key, items are rated with a 0 to 2 format. A zero (0) reflects that a potential treatment domain does not currently require 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 treatment domain is a moderate need (Moderate Need = 1). A two (2) indicates the area requires significant intervention (Significant Need = 2). When the RNI is re-administered during the course of treatment, lower ratings on items than recorded previously may reflect treatment progress, whereas higher ratings may reflect a need for more intensive intervention. Behavioral anchors are provided in the Rating Key to assist with item ratings.

RNI ratings should be based on multiple sources of information whenever possible, such as school and other available records, and also self and other credible 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 be underestimates, 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. We have an enormous burden of responsibility. 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 in individuals, 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 protective factors and related treatment needs among college students who have engaged in sexual misconduct be very knowledgeable of the challenges
involved in assessing this population. Although, in most instances these students are legally adults, most of them are developmentally and emotionally adolescents. Their cognitive, social, and emotional development is 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. As treatment interventions begin and progress, risk and protective factors and treatment needs may change, sometimes dramatically, in a relatively brief period of time. Therefore, we strongly recommend that risks and needs be assessed at intake, and then reassessed at least quarterly throughout the course of treatment, with a final RNI assessment occurring 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 regarding those who engage in sexual misconduct. Users should read the manual and be very familiar with its contents. Ideally, before using the scale in any professional capacity, 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, and stay current with the evolving literature relevant for assessing and treating college students who engage in sexual misconduct.
RISK & NEEDS INVENTORY – TV

Name: ___________________________________  Age: __________
Note: Intake ____ Interim ____ or Final ____ Dates covered: ___________________
Treatment status: Active____Refused_______Dropped out_______Completed _____
Number of sessions this period: Offered _______Completed ______ Refused __________

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15. Other* | 0 | 1 | 2

*Other goals (optional):

Summary of Treatment Needs:

Therapist signature: ___________________________ Date Completed: __________

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RISK & NEEDS INVENTORY – TV

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. Generally accepts some responsibility for sexual misconduct, although occasional excusing or redirecting responsibility may be present. If the individual denies responsibility for the referral offense, 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:**

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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 ratings 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 ratings of 1 or even 0 may be used to reflect recent improvement, for example, as indicated by increased skills for managing sexual self-regulation.
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 inapt 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. During the past six months, demonstrates the ability to deal with frustration or conflict without becoming unduly upset, argumentative, destructive, or aggressive. Is able to express emotions appropriately and act accordingly and responsibly. No significant incidents involving emotional dysregulation have occurred within the past six months (excluding the sexual misconduct referral).
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 used 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/Significant Progress.** 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 lifestyle *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.* Consensual sexual behavior appears to be the norm and generally occurs within an ongoing relationship. Individual has a history of 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 as well as 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:**

164
0 **No or Minimal Need.** The individual has at 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.

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**Item 15: Other (optional)**

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.

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Clinician Note:

This Brief Assessment and Interview Guide is designed to facilitate the intake assessment for the STARRSA treatment program. This intake assessment is not a comprehensive evaluation, but is important for gathering sufficient information to inform treatment planning. Findings from the client interview can be used in conjunction with information from other sources to complete the Risk and Needs Inventory (RNI), a structured assessment instrument that is designed to help identify relevant treatment needs, and facilitate pertinent and well-focused interventions.

It is important to recognize that the STARRSA treatment program allots only two sessions in Module 1 for orientation and assessment. Especially early in treatment clients may be reluctant to disclose personal and private information and you may not want to spend significant time attempting to elicit such information. By focusing on less sensitive questions first, sufficient rapport may develop to broach more sensitive questions, especially regarding the individual’s sexual history. Thus, with some clients, it may be best simply to engage them in disclosing less sensitive personal information, gather basic information and begin treatment. As the therapeutic alliance develops, the client hopefully will be more open about more sensitive matters.

As treatment proceeds, the client may share additional information that will warrant updating the Risk and Needs Inventory (RNI) and the treatment plan. It is recommended that the RNI and treatment plan be updated (at minimum) quarterly unless new information warrants a sooner update, as well as for guiding discharge planning. In some instances, a more in depth clinical interview and assessment may be necessary to evaluate signs or symptoms of a psychiatric disorder and the possible need for psychotropic medication. Referrals for appropriate evaluations may be necessary.

Because the intake assessment will follow the informed consent process, information about the limits of confidentiality may be fresh in the client’s mind. It still may be important to reiterate key points given the sensitive nature of some of the questions, and the answers the client may provide (e.g., regarding rule violating and illegal behavior, sexual activities and misconduct, etc.). The client should be encouraged to answer honestly and forthrightly but also to let you know if and when certain topics are off-limits, at least for now. Just as honesty is valued, decisions not to answer certain questions should be respected. It may be helpful to inform the client at the beginning of the intake assessment that due to the nature of the referral (sexual misconduct), questions about...
sexual development as well as sexual thoughts, beliefs, behaviors and practices are routinely asked and will be a focus during this intake assessment, as well as during treatment. This heads-up may help the client better understand the questions being posed and become more able to engage in the therapeutic process.

Information sources:

Useful information sources may include the following:

- Clinical interview (Total approximately 1 – 1.5 hours)
- Collateral interviews (e.g., partners, mentors, parents)
- Records reviewed (e.g., school records, prior psychological reports)
- Psychological tests, if indicated
- Whatever information is provided by the referring student conduct personnel

Most of the assessment information, however, is likely to come from a focused clinical interview.

It is recommended that the clinician review available information prior to the first appointment.

Introduction to the assessment:

- Briefly orient the client to the assessment and treatment, e.g., the purpose of the assessment and treatment are to identify risk and protective factors associated with sexual misconduct and develop strategies to mitigate or resolve risk factors, enhance protective ones, and enable the client to successfully achieve his/her academic, vocational, social, and personal goals.
- Inform the client that due to the nature of the referral you will be asking some very personal questions about sexual attitudes, feelings, and behavior. Emphasize that, above all else, candid, sincere, honest answers are most important. If the client does not wish to answer a particular question, saying so is fine, as long as the client responds candidly.
- Ensure informed consent. Review the limits of confidentiality, mandated reporting requirements, and who may or will have access to assessment and treatment information and specifically what information they may see.
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 and Needs Inventory (RNI) and enable the clinician and client to identify 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 and 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.

Room is provided for brief “Observations” (or notes) after each section. If more room is needed, complete the interview with your laptop or additional paper. If you wish, you may place the individual RNI items on your laptop and type in notes directly during the interview.

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 will 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?
- Now that you have learned a little about this program, what are your thoughts and feelings about participating?

Observations:
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**Significant History**

**Family of Origin**

(Possible RNI relevance for Item 14, possibly Item 4 & 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:

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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?

*A possible probe may be: “Do school records indicate instances of sexual comments or behavior that were thought inappropriate?” However, such a question at this stage may
alienate the student and not be answered honestly. Asking the client for consent to obtain school records may be a useful alternative.

Observations:

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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:
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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:
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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?
• What types of bad conduct reports for you are on file? Did you receive any medals, awards, or other achievements?
• How has the transition to civilian life been? How have you managed / succeeded?

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 over time?)
• 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?
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:
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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 an 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 other 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:

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Personal Maltreatment History
(Possible RNI relevance for Items, 1, 2, 4, 6, 8, 9, 10)
• 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 parents or caregivers able to provide for you and any siblings basic needs (e.g., food, clothing, medical needs, shelter)? How were caregivers supportive and nurturing, or 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? (NOTE: If the person is identifiable and the client was a child, a mandatory report may be required. A reminder about mandatory reporting before the person responds may be indicated). What was your relationship? How often did it happen, for how long? Were there other people who did this to you? (Same questions).
• How often do you think about these experiences? How did they affect you? How do you think it affects 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, this may require intervention before or concurrent with STARRSA treatment (Item 2 & 8)

Observations:
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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 date rape drugs, 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, but is not included in this Brief Assessment and Interview Guide. (Substance abuse screening tools such as the CRAFFT or MAST may be useful, e.g.: http://www.ceasar-boston.org/CRAFFT/index.php; https://ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf ). Given time constraints, a brief review may be sufficient for STARRSA and a referral for additional assessment may be made if indicated.

- 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, i.e., 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:

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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 or major crises? How effective are these strategies? What else has been helpful? Would you like to learn new ones?
• Similarly, in general, what do you do to manage strong upsetting or angry emotions? 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?
  ▪ When, where, and with whom 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)
  ▪ When, where, and with whom has your temper been a problem for you or others (e.g., with friends, partners, family, teachers, bosses, etc.)?
  ▪ 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:
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**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?
  - 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)?
- How often have you seriously thought about harming yourself? What precipitates such thoughts? What action have you taken? (i.e., assess suicidality, risk of self-injury, and harm to others – having reviewed mandated reporter responsibilities)
- Who knows of these challenges? How do they respond? Do you feel you have support when it would be helpful? Who do you turn to?

Observations:

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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 answer dishonestly.

- 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? If yes, possible reasons why? What was going on at the time?
  - 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?
• How often do you to look at it / masturbate to it each day?
• What, if any, concerns do you have about your pornography use? (e.g., interferes with school, relationships, etc.)

• 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”? 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?
    o Any unintended pregnancies – children?
    o STDs?
    o 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:
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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 sexual misconduct resulted in your being here today?
- Walk me through what happened, step-by-step, prior, during, and after the incident/s.
- What do you recall thinking and feeling during the incident/s?
- What are your thoughts and feelings about what happened now?
- If you could redo that day (or those days) when the sexual misconduct happened, what, if anything, would you do differently?
• Additional Sexual Misconduct:

  ▪ Has any sex behavior gotten you in trouble before? If so, what happened? (If possible, explore the types of behaviors, such as exposing, peeping, groping, intercourse, and use of force and violence, as well as level of impulsivity or planning, circumstances, such as “partying” compared with drugging, isolating or stalking, photographing or videoing, and possibly distributing the pictures. Also discuss consequences of the misconduct for the individual, e.g., informal, school, and legal and others, e.g., victim, family members).
  ▪ How old were you the first time? How often have you been in trouble because of your sexual behavior? (Explore similar factors as above).
  ▪ What led up to the sexual misconduct for which you were referred? Walk me through what happened. What feelings, thoughts, situations, decisions led up or contributed? What did you do afterwards? What were your thoughts, feelings?
  ▪ Were there times that you thought about doing this, but did not? Why not?
  ▪ 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:

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Victim Awareness
(Possible RNI relevance for Items 1, 2, 4, 5, 6, 10)

• What were you and the complainant doing before the sexual incident?
• How did the interaction become sexual?

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• What did the other person say or do? (Before, during, and after)
• How did the person seem to be feeling?
• How did/do you feel about this person’s reaction?
• What do you think this experience has been like for the person who filed the complaint against you?
• 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.)
• 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:
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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?)

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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?

What changes do you think you need to make? What about yourself do you value, and want to keep?

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:
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The RNI Interview is an accompanying product to the STARRSA: Science-Based Treatment, Accountability, and Risk Reduction for Sexual Assault program, part of an ongoing project (Grant # 2014-AW-BX-K002) funded by the United States Department of Justice, Office of Justice Programs [Office of Sex Offender Monitoring, Apprehending, Registering, and Tracking]. The Principal Investigator is Robert Prentky, PhD, and the Co-Principal Investigator is Mary Koss, PhD. For more information, please contact the Project Managers, Raina Lamade, Ph.D. at lamade@fdu.edu, or (631) 748-7687 or Elise Lopez, Dr.P.H. at eclopez@email.arizona.edu, or (520) 621-4916.
APPENDIX D

- **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
    - Dear Son Letter: Son It’s OK if You Don’t Get Laid Tonight
    - How 7 Things That Have Nothing to do With Rapt Perfectly Illustrate the Concept of Consent
    - Sex and the Law Supplemental handout
  - PowerPoints
    - Sex and the Law
    - Changing Times
    - Drugs and Rape
    - Groupthink
    - Negative Masculinity
    - Socio-cultural Context of Rape (Rape Culture and Rape Attitudes)
- **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.
  - Additional multimedia resources
ACTIVITIES AND MATERIALS:

*Handouts and 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.

- 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.”

- 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.

- 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’s 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.

- 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 quiet 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, hit her again knocking her unconscious before fleeing the scene. She was discovered by another jogger.

• 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?
  o 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?
  o 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.
  o 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?
  o 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:
  o 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

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

Ask the client: How much do you 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

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11 Ibid

Attitudes & Beliefs about Men and Women

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 dissimilar 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 reinforced during my child, 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.

<table>
<thead>
<tr>
<th>Statement/Thought</th>
<th>0</th>
<th>3</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women have an obligation to meet their husband's sexual needs</td>
<td>NO, absolutely not</td>
<td>MODERATELY, sometimes</td>
<td>YES, strongly</td>
</tr>
<tr>
<td>When women wear short skirts or tight tops, they are just asking for sex</td>
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<tr>
<td>Most reported rapes are false</td>
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<tr>
<td>Women are good for only one thing</td>
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<tr>
<td>Many women cry rape after regretting sex the morning after.</td>
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<tr>
<td>Women can be really manipulative</td>
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<tr>
<td>Women can successfully resist a rapist if she really wanted to</td>
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<tr>
<td>If a woman goes home with a man on their first date she wants to have sex</td>
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<tr>
<td>Cock teasers get what’s coming to them</td>
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<tr>
<td>Nice girls don’t get raped</td>
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<tr>
<td>A woman who has sex on the first date is a whore</td>
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<tr>
<td>Women typically don’t deserve the same pay as men, even if they have the same job.</td>
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<tr>
<td>There are some jobs that are just not for women</td>
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<tr>
<td>If a woman gets drunk at a party and has sex with a guy she’s just met, she should be considered “fair game”</td>
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<td>Statement</td>
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<tr>
<td>Women should take care of children and the house not want a careers</td>
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<tr>
<td>Many women have an unconscious wish to be raped</td>
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<tr>
<td>In most rapes, the victim was promiscuous</td>
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<tr>
<td>Many women cause their own rape by the way they act and the clothes they wear</td>
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<tr>
<td>Campus sexual assault has been blown out of proportion by women</td>
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<tr>
<td>Most men that are accused of rape are really innocent</td>
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<tr>
<td>Campus sex isn’t rape because when women go to parties sex is just part of partying</td>
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<tr>
<td>If both persons are drinking then neither can be held responsible for a sexual assault</td>
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<tr>
<td>Women like a tough, strong man who tells them how it is</td>
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<tr>
<td>Women say no even though they really mean yes to sex.</td>
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<tr>
<td>Being roughed up is sexually exciting to many women</td>
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</tbody>
</table>
Attitudes and Beliefs Worksheet: *Negative 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.

<table>
<thead>
<tr>
<th>Statement/Thought</th>
<th>0</th>
<th>3</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can take a beating as well as any man.</td>
<td></td>
<td>MODERATELY, sometimes</td>
<td>YES, strongly</td>
</tr>
<tr>
<td>When I have a drink or two I feel ready for whatever happens.</td>
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<tr>
<td>Any man who is a man needs to have sex regularly.</td>
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<tr>
<td>I’ve always wanted to have a really fast sports car.</td>
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<tr>
<td>If you’re not prepared to fight for what’s yours, then be prepared to lose it.</td>
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<tr>
<td>When women go braless and wearing short skirts and tight tops they are just asking for trouble</td>
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<td>I’d rather gamble than play it safe.</td>
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<tr>
<td>I’ve been told I take foolish risks.</td>
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<tr>
<td>A strong man never cries</td>
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<tr>
<td>It’s natural for men to get into fights.</td>
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<tr>
<td>Sometimes the only way a man gets a cold woman turned on is to use force</td>
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<tr>
<td>I like wild, uninhibited parties.</td>
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<tr>
<td>I never let another guy get one up on me.</td>
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<tr>
<td>Get a woman drunk, high, or hot and she’ll let you do whatever you want.</td>
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<tr>
<td>I tend to self-centered.</td>
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<tr>
<td>There are times when a husband or boyfriend needs to discipline his wife or girlfriend.</td>
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<tr>
<td>I never feel bad about my tactics when I have sex.</td>
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<tr>
<td>I have destroyed things just for the hell of it.</td>
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<tr>
<td>A lot of women seem to get pleasure in putting men down.</td>
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<tr>
<td>A man should beat a guy who insults his woman</td>
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<tr>
<td>After I’ve gone through a really dangerous experience, I feel high.</td>
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<tr>
<td>A woman will only respect a man who will lay down the law to her.</td>
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<tr>
<td>I remind myself that I’m “number one” and have to look out for myself first.</td>
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<tr>
<td>I like fast cars and fast women.</td>
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<tr>
<td>I can hold my own with anybody when it comes to drinking.</td>
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<tr>
<td>My needs come first.</td>
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<tr>
<td>A lot of women seem to get pleasure in putting men down.</td>
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<tr>
<td>I like to drive fast, right on the edge of danger.</td>
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<tr>
<td>I’ve gone out with a lot of women.</td>
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<tr>
<td>I work out with weights to keep my muscles in shape.</td>
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<tr>
<td>Some women are good for only one thing.</td>
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<td>Statement</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>I’d rather gamble than play it safe.</td>
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<tr>
<td>Sometimes a man is justified in hitting his wife.</td>
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<tr>
<td>I would rather be a famous prizefighter than a famous scientist.</td>
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<tr>
<td>I’ve thought about carrying a concealed weapon.</td>
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<tr>
<td>When I’m bored I look for excitement.</td>
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<tr>
<td>Women appear to tell the truth, but I know otherwise</td>
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<tr>
<td>Pick-ups should expect to put out.</td>
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</tbody>
</table>
Experiential Exercises

The following experiential exercises are located on the accompanying flash drive.

- 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…
CERTS Handout

Hard copies provided for pilot. See flash drive for hand out.
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 a respectful and mutually rewarding way. 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 confidants 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…

8. **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…

9. **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…

10. **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.

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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

*Well this is all a very brilliant way to show what it's all about.*

In 2013, Zerlina Maxwell ignited a firestorm of controversy when she strongly recommended we stop telling women how to not get raped.

Here are her words, from the transcript of her appearance on Sean Hannity's show:

"I don't think that we should be telling women anything. I think we should be telling men not to rape women and start the conversation there with prevention."

So essentially — instead of teaching women how to avoid rape, let's raise boys specifically not to rape.

There was a lot of ire raised from that idea. Maxwell was on the receiving end of a deluge of online harassment and scary threats because of her ideas, which is sadly common for outspoken women on the Internet.

People assumed it meant she was labeling all boys as potential rapists or that every man has a rape-monster he carries inside him unless we quell it from the beginning.

But the truth is most of the rapes women experience are perpetrated by people they know and trust. So fully educating boys during their formative years about what constitutes consent and why it's important to practice explicitly asking for consent could potentially eradicate a large swath of acquaintance rape. It's not a condemnation on their character or gender, but an extra set of tools to help young men approach sex without damaging themselves or anyone else.
But what does teaching boys about consent really look like in action?

Well, there's the viral letter I wrote to my teen titled "Son, It's Okay If You Don't Get Laid Tonight" explaining his responsibility in the matter. I wanted to show by example that Maxwell's words weren't about shaming or blaming boys who'd done nothing wrong yet, but about giving them a road map to navigate their sexual encounters ahead.

There are also rape prevention campaigns on many college campuses, aiming to reach young men right at the heart of where acquaintance rape is so prevalent. Many men are welcoming these efforts.

And then there are creative endeavors to find the right metaphors and combination of words to get people to shake off their acceptance of cultural norms and see rape culture clearly.

This is brilliant:

There you have it. Seven comparisons that anyone can use to show how simple and logical the idea of consent really is. Consent culture is on its way because more and more people are sharing these ideas and getting people to think critically. How can we not share an idea whose time has come?
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)
  - 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.
Sex and the Law: Campus Sexual Misconduct
Sex and the Law:
Campus Sexual Misconduct

Recommended for Module 2

SAARRA:
Science-based Treatments, Accountability and Risk Reduction for Sexual Assault

A Project Federally-funded by the United States Department of Justice
Office of Justice Programs, Family Violence, Domestic Violence, Sexual Assault and Turkery

Principal Investigator
Rabi Guha, Ph.D.
Northwestern University

Co-Principal Investigator
Mary L. A. M. Woodworth, Ph.D.
The University of Arizona

Sexual Misconduct:

- General categories of sexual misconduct are described in the following slides
- Specific state or federal sexual offenses are not described
- Knowledge of relevant State and Federal laws and institution policies is strongly advised

Rape

- The penetration, no matter how slight, of the vagina or anus, with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. This offense includes the rape of both males and females.
- Example: A female student reported her ex-boyfriend had sex with her in her campus residence hall room against her will because he was angry that she began seeing someone else.
- Example: A female student reported a male student raped her while she was in and out of consciousness from drinking at a fraternity party.
- Example: A freshman male reported he was forcefully penetrated with an object as a “welcome” to the older student’s sports team.

Statutory Rape:

- Sexual intercourse with a person who is under the statutory age of consent.
- 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 below.

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!”

Topics Covered in Today’s Session

- Definitions 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
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: Two male students join a couple of female students in the school dining hall. One starts playing suggestively with a banana. One of the female students tells him to stop. The other student says: “Aw, don’t you want to hear what he’d really like to do to you?”


“Sexting” as 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.

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. Expessed 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.
  ➢ 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;
  - 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.

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.

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."

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 related 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 raped by a former friend in a dorm room which she was physically prevented from leaving, 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 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.
- 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.


Child Pornography (continued)

- 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. Mail 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-vacitizens-guide-to-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 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:
  - Reproductive 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.
Supplemental Slides:
Dating Violence, Domestic Violence, and Stalking:

The slides that follow regarding Dating Violence, Domestic Violence, and Stalking may be moved forward and weave 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.


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 in common;
  - 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.

  - 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.
Is this rocky road because “times are changing”

Let’s take a glimpse at the shrinking differences between men and women when women are allowed to compete on an equal playing field.

The Playbook in action again? a cataclysmic societal shift?
Are we seeing the signs of “a change wrought by the sea” (from The Tempest)?
in colloquial terms – a sea-change?
producing a tidal wave of resistance
by men with a masculine identity that does not include gender equality?

Let’s take a look @ Pop-Culture

Pop-Culture
Professionally
Academically
Athletically
Militarily
Politically

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; she does not rely on men – a trait you associate with every male hero
She kisses the boys – but evidences no clinging dependence on them; if anything, she rescues them rather than the reverse

Mad Max: Fury Road  Charlize Theron is the savior of the many “wives” of Mad Max*

Again, that is characteristically the role of the man to rescue the (helpless) fair maiden in distress

*Assisted by a band of gray-haired, motorcycle matriarchs

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 noted (at least publically) in women
• We are seeing that “higher-primate response” more and more frequently in women athletes

By 2014, the number of women in high school sports increased 11x (elevenfold) 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.

• The 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.

“True champions aren’t always the ones that win, but those with the most guts,”
Mia Hamm

Again, higher primate – teeth bared more typically seen in male athletes
guts? Again a term used exclusively for exceptional heroism in men

Mia Hamm’s comment
• “True champions aren’t always the ones that win, but those with the most guts,”
Mia Hamm
• 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”

Abby Wombach
Same with Abby Wombach:  
higher primate, teeth barred,  
typical of men in extreme, often  
life-threatening situations

- May 10, 2015, collision with Ireland goalkeeper, Wombach  
broke her nose but remained in the game – “Her resolve  
unbreakable, Her nose? Well…”  
- 2008, Wombach lifted on to a stretcher after injuring her  
leg in a collision with a Brazilian player

• 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.

• Difference? Again, Rocky is a fictional  
character. In real life, he probably would have  
left the ring! Wombach is not fiction. As was  
quoted: “Her resolve unbreakable…”

Serena Williams

• Not just a star athlete but referred to now as a  
“superstar” who has defined & dominated a sport  
more than any other athlete in history  
• She was won 23 Grand Slams;  
• the 23rd was the Australian Open at age 35 and 2  
months pregnant! and did not drop 1 set in the  
entire match

Serena Williams: Wimbledon Day 12
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 Pacienda, is widely viewed as one of the hardest pure rock climb 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.”

93% of the men that tried, died
Sasha succeeded

Sasha

- 22 y.o. was UG @ 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 women did what 64+ men died trying to do
Mt. Everest?

- Anshu Jamsenpa, an Indian woman, set a new record after she climbed Mount Everest twice in less than a week (2017).
- In 2011, she did her first double ascent of Mt. Everest, that time in 10 days.

- She appears to have accomplished what the 29 year old Catalanian (Spanish) 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 remarkable feat in context:

- If American male athletes never attended the Olympics, and the U.S. was only represented by women:

<table>
<thead>
<tr>
<th>Country</th>
<th>Gold Medals Won</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Britain</td>
<td>27</td>
</tr>
<tr>
<td>American women (only)</td>
<td>27</td>
</tr>
<tr>
<td>China</td>
<td>26</td>
</tr>
<tr>
<td>America (Russa)</td>
<td>19</td>
</tr>
</tbody>
</table>

Place in the world
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 golds in track and field.

the back story

- that same year, the U.S. Congress passed Title IX, barring sex discrimination in education programs that receive federal funding. Title IX revolutionized women’s sports, beginning in high school and most significantly in college.

- Title IX is a portion of the United States Education Amendments of 1972

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 alarming in the short term.

- In the long term, it will decrease the most toxic discrimination.

Military
“These 2 badass female Army Rangers just made history”

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 said

Gender Completion of Ranger School

- Men: 94 out of 380 – 24.7% passed
- Women: 02 out of 18 – 11.0% 1st time

“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 alchemically bonded... the real reason many Marines don’t want women in the infantry is that it will forever change that culture.”

Again, male terminology used to describe women doing what (some) men were able to do

physically, they were studs...
are women “fit” for combat?

- If “fit” is defined as possessing the strength, stamina, and capacity to kill, the answer clearly is yes.
- 55-60% of the Israeli Defense Force are women – there is full integration
- Canada fully integrated women into the army in 1989

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
---|---|---
Gandhi, India | India | 2x – 65-77, 80-84
Dakovic-Kuruzic, S. | Croatia | 67 – 69
Mer, Lydia | Israel | 82 – 74
Dorsten, E. | Central African Republic | 75 – 75
Thatcher, Margaret | United Kingdom | 78 – 80
De Laveder Pintasigo | Portugal | 79 – 80
Charles, M. E. | Dominica | 80 – 95
Bristow, Opal | Norway | 3x – 81, 86-89, 90-94
Pleas, M. | Yugoslavia | 82-85
Shah, Benazir | Pakistan | 2x – 88-90, 93-96
Pinchovski, A. | Lithuania | 90-91
Zia, K. | Bangladesh | 2x – 91-95, 01-06
Cresson, E. | France | 91 – 92
Suwolacka, H. | Poland | 92 – 93

Baptista de Sousa, M. | Sao Tome and Principe | 87 – 83
---|---|---
Jassemović, A. | Finland | 93
Lucero, B. M. | Peru | 93
Ciengo, L. | Mozambique | 94 – 93
Seferinova, R. | Macedonia | 2x – 04
Tymoshenko, Y. | Ukraine | 2x – 07, 07-10
Carmo Silva, S. | Sao Tome and Principe | 06 – 06
Merkel, Angela | Germany | 3x – 2005 – present
Simpson-Miller, P. | Jamaica | 2x – 06, 11, 12
Sook, H. M. | South Korea | 06 – 07
Grecoevi, Z. | Moldova | 08 – 09
Pierre-Louis, M. | Haiti | 08 – 09
Sigurdardottir, J. | Iceland | 09 – present
Kosir, J. | Croatia | 09 – 11
Matunzishana, C. | Madagascar | 09

Anglo Countries | Women Head of Government | Wealth
---|---|---
Australia | Y | wealth = power
Denmark | Y | historically, wealth has
Norway | Y | always been held by men
Finland | Y | men
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 | 

Fernández de Kirchner, C. | Argentina | 03 – 07
---|---|---
Martínez de Perón, I. | Argentina | 74 – 76
Otumbayaye, R. | Kyrgyzstan | 10
Persad-Bissessar | Trinidad and Tobago | 10 – present
Kivimievi, M. | Finland | 10 – 11
Gillard, Julie | Australia | 10 – 13
RadicCova, I. | Slovakia | 10 – 12
Figureau, R. F. | Peru | 11
Siddie, 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

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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, both from their 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

- 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% of the purchase decisions for their households. – Karen Vogel, The Women’s Congress and co-founder and president of New Generation Event Solutions

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

- 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

Female Power Brokers Invading the Male Citadel

- Name me the 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; he 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 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”?
other world leaders in technology:

- Mary Barra, CEO of General Motors;
- Marilyn 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;
- Susan Wojcicki, CEO of YouTube

World of Finance

- Janet Yellen, 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
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
- The racist rhetoric and misogynistic rhetoric will (mostly) disappear 50 years from now after the 2nd or 3rd Black President and Female President are elected

The world is increasingly flat; Times-a-Changin in the U.S. and for some – change is very scary....

- 1. a wave of legislation is legalizing marijuana at the state level – Nov 6 NY Times Editorial “Push for Legal Marijuana Spreads”
- 2. a wave of legislation is approving same-sex marriage in states around the country
- 3. 8 years of the 1st Black President of the U.S.
- 4. linear decline in # of Americans reporting adherence to practice of mainstream religion

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 gender equality

- When men finally 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

This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.
Drugs & Rape
Drugs & Rape

- Alcohol
- Barbiturates
- Cocaine
- “Rape Drugs”

In 1997, Americans drank an average of 2 gallons of alcohol per person.

This translates roughly into one six-pack of beer, two glasses of wine and three or four mixed drinks per week.

Since roughly 35% of adults do not drink, the numbers are much higher for those who do – Alcohol is the most common “social lubricant”

ALCOHOL

The order in which alcohol affects the various brain centers:

- Alcohol affects many areas in the brain, but NOT equally given the same Blood Alcohol Concentration (BAC)
- The higher-order centers are MORE sensitive than the lower-order 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 also enhances the effects of the neurotransmitter GABA, which is an inhibitory neurotransmitter.

Enhancing an inhibitor has the effect of making you sluggish, which looks like the behavior you see in a drunk person.

Alcohol also reduces Glutamine, an excitatory neurotransmitter, making this excitatory neurotransmitter less effective, also producing this “sluggishness”

- How fast the alcohol is absorbed depends upon several things:
  - 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 the 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 (BAC - blood alcohol concentration).

The effects of alcohol depend on the BAC, which is related to the amount of alcohol consumed.

The BAC can rise significantly within 20 minutes after having a drink.

**Effects of Alcohol on Men v. Women**

- men tend to have more muscle tissue 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, and the woman will feel the effects of the alcohol sooner than the man will.

**the effect of Antabuse**

- 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 severe hangover.

**alcohol is highly toxic**

**a hangover, simply stated:**

is taking alcohol on board faster and in greater quantity than your body can break down (oxidize it) into acetic acid

(barring other obvious factors, such as food in your stomach)

from any health perspective, inhaling alcohol is just plain stupid!

This is a “short list” of “mild” symptoms of intoxication

- Flushing
- Nausea
- Cephalic Vomiting
- Sweating
- Thirst
- Throbbing in the Head and Neck
- Throbbing Headache
- Respiratory Difficulty
- Chest Pain
- Paresthesia
- Dyspnea
- Hyperventilation
- Tachycardia
- Hypotension
- Syncope (fainting)
- Marked Uneasiness
- Weakness
- Vertigo
- Blurred Vision
- Confusion
Approximate behavioral effects of various blood alcohol levels

- .09 - .21 “stimulation’
- .15 legally drunk
- .20 - .30 confusion, slurred speech, ataxia
- .30 - .40 severe intoxication
- .50 - .80 death

BAC ≥ .20

most people begin to experience blackouts

blackouts

- It is estimated that roughly 75% of all college students consume alcohol and many engage in binge drinking.
- Blackouts are now increasingly common among college students – blackouts are not just 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:

- "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."

Moreover, the adolescent brain is more vulnerable to the neurotoxic effects of alcohol than the adult brain, according to Dr. White.

The 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 greater risk for negative consequences, including unwanted, non-consenting sex.
As a rule of thumb, a BAC > .15

Decision-making adequate for consenting to sex is severely undermined

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**BARBITURATES**

- Barbiturate intoxication – similar to alcohol intoxication
- Withdrawal symptoms similar
- Barbiturates SEDATE – relieve stress & anxiety;
- Users become more sociable & good-humored – as with alcohol
- Users experience lack of coordination, ataxia, & slurred speech, same as with alcohol

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**There are 2,500+ barbiturates**

- Intoxicating doses of the more popular ones last about 4 hours

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**COCAIN**

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**translating to # of drinks**

<table>
<thead>
<tr>
<th>6 drinks</th>
<th>7-8 drinks</th>
<th>10 drinks</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAC = 0.12</td>
<td>BAC = 0.15</td>
<td>BAC = 0.20</td>
</tr>
<tr>
<td>vomiting</td>
<td>point at which you have trouble walking straight</td>
<td>blackouts &amp; memory loss</td>
</tr>
</tbody>
</table>
Erythroxylon coca

- Powder from coca leaves potentiates the effects of sympathetic nerve stimulation;
- A rise in core temperature, partly because of increased muscular activity and partly because of vasoconstriction (constricted blood vessels);
- In addition to constricted peripheral blood vessels, other physical effects include dilated pupils, heart rate, and blood pressure.

Smoking (as opposed to snorting) 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

This is the most common two-drug combination that results in drug-related death.

Rohypnol - #1 Rape Drug

"RAPE DRUGS"

Goes under many names on the street:

Roofies, Rophies, Roche, Forget-me Pill, Circles, Mexican Valium, Rib, Roach-2, Roopies, Rope, Ropies, Ruffies, Roaches.

Rohypnol

- Rohypnol is a benzodiazepine (Flunitrazepam)
- sold legally in Latin America & Europe as a short-term treatment for insomnia and as a pre-anesthetic

- Drop in blood pressure, drowsiness, visual disturbances, dizziness, confusion, GI disturbances & urinary retention.
- Users: feels similar to intoxication but wake up the next morning without a hangover.
- 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, and many commercial toxicological screens do not detect it.
- In sexual assault cases, forensic laboratories screen for the metabolite of Rohypnol (7-amino-flunitrazepam)
Physiological effects very similar to Valium (diazepam), but it is approximately 10 times more potent than Valium

A similar drug is Klonopin (clonazepam)

why used in rape?

***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!!

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.
Intoxication from A & R can result in "blackouts" lasting 8 to 24 hours following ingestion.

Immediate Effects of R

About 10 minutes after taking R, you feel dizzy and disoriented, simultaneously too hot and too cold, or nauseated.
You may experience difficulty speaking and moving before passing out.
Victims typically have no memories of what happened while under the influence of the drug.

Legal?

No!

It is not manufactured or sold legally in the United States.

It is smuggled into the U. S. and can be purchased very inexpensively on the street – roughly $5

#2 GHB (gamma-hydroxybutrate)

Again, many street names:

"liquid ecstasy," "somatomax," "scoop,"
"grievous bodily harm," Georgia home boy, liquid X, liquid E, G-Riffick,

organic quaalude, and Easy Lay
GHB

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 / rape in cites throughout the world

GHB Effects

- Effects are highly dose-dependent
- Steep dose-response relationship
- i.e., small increases in the amount taken lead to significant intensification of the effect

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

Legal?

Gray Market

It is currently regulated in the US and sold under the name Xyrem, generally bootleg (produced, distributed & sold illegally)

#3 - 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 and memory, sometimes for days.

- 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 rape and robbery

- A young American woman visiting Bogota 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.

What IS Burundanga?

• Like the stronger benzodiazepines, it can induce retrograde amnesia.

Overview

✓ 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 for NO purpose other than committing a felony – rape. Bringing one of these drugs to a party implies – premeditation – the intent to rape.
Groupthink: Why We Act Like Sheep
Groupthink: why we act like sheep

- George Orwell's book (1949) *1984* --- newspeak introduced terms like “doublethink” and “crimethink”
- 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

Groupthink

- animals travel in herds, mostly for protection from predators; even many predators like lions hunt in “herds”.
- *Herding is an adaptive strategy.*
- 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”

In extreme cases, Groupthink leads to a loss of ability to think for yourself “mind meld” with the group

An extreme example of Groupthink is a cult

like Charles Manson

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 ingroup – 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.”

At its worst, groupthink paved the way for, and insured the life span of and disastrous consequences of numerous morally bankrupt social institutions:

- slavery
- McCarthyism
- Salem trials of “witches”
- Not to mention fascist regimes like Hitler’s Third Reich

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—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? 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...
- 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,” 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 1 single “hero” that is known for creating victims?
Negative Masculinity
Negative Masculinity

stereotypic attitudes, beliefs, and behaviors associated with masculinity and with male-female interactions, including the hallmark of sexual entitlement

Professor Malamuth’s Confluence Model

Malamuth proposed a two-path model in which:
(1) negative masculinity and
(2) impersonal sex
were the major predictors of sexual aggression
(Malamuth, 2003)

What is Negative Masculinity?

- risk-taking
- defending one’s honor above all else
- hyper-competitiveness
- 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, drinking)

Scales

many scales 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 rape 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 that 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.
Attitudes Supporting Negative Masculinity

- 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 work out with weights to keep my muscles in shape
- I've always wanted to own a really fast sports car
- I've gone out with a lot of women
- I have destroyed things just for the hell of it
- I have one or more tattoos

Attitudes 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, because they have been—and continue to be—reinforced by a culture that supports such attitudes as normal:

So if what I think about masculinity is "negative," what is "positive" masculinity?

- For starters, men with positive masculinity have no more need to steal sex than steal a quart of milk from the market.
- Rape is stealing sex; it is also a felony.

Men with negative masculinity are, at their core, insecure

- Men with positive masculinity have self-confidence;
- they have self-esteem; they are self-assured, these are qualities that women admire.
- Men that are socially successful, the guys in high school that were most popular with the girls, were not successful with the girls because they had to "take" what wasn't offered.
- they were successful because they exuded confidence and were offered what they received
• 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.
  • 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”).
  • We do not honor those who put others in danger!

• Melting the Divide
  • 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 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!

• Can you think of just 1 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, 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.

• 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.
• Self-admiration is only when no one else will.

• 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.” The title of the book has become a part of pop culture.
the greater the perceived similarities and the fewer the perceived differences, the more women become like “bros.”

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.

Most of us actually fall all along a continuum with respect to those traits – and – amazingly, so do women!

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**Sacked by the Media Blitz**

*Dana Jennings, New York Times, 11/24/2013*

- “...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!”

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- “...the marketers think they know the men who are watching – and it is still mostly men – and what their deep-down desires are:
  - tanklike 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 component of what it means to “be a man” is having lots of sex. With lots of women. Only with women, never with men 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
• The game of scoring is tallying as many cute chicks 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.”

The “Game”: Sexual Conquest

• Now let’s be clear, there is nothing wrong with having lots of sex! But when men set their value and worth on how much sex they are having to make sure they are having enough sex 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” is just a nuisance – an obstacle in your path, something to ignore or get around or “finesse”
• Guys are “using” women to bolster their credentials – their bona fides – as real men.
• 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 their 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.

- How does it make me feel more like a man when I had to get the women drunk into unconsciousness 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 peer pressure mounts because your score card provides meager evidence of your manliness, you may resort to tactics that cross the line to rape.

- With all men “out to score,” it places the burden of preventing rape 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 5s the next day. The sex was meaningless.

- 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? The next day?
Socio-cultural Context of Rape: Attitudes About Women Explicitly Expressed in Mass Marketing / Advertising
Socio-cultural
Context of Rape:
Attitudes about Women
explicitly expressed in mass marketing / advertising

Prevailing Attitudes
About Women:
1950’s – 1970’s

Not very bright but teachable

Role: Vacuuming

Role? The House Maid
Role: Cooking; it's what wives are for

Role: Keeping up with the House

Role: Feeding your man in bed on your knees: “show her it’s a Man’s World”

Apparently it is “manly” to blow smoke in a woman’s face

and if she fails to “store-test” the coffee for freshness, throw her over your knee and spank her

Your Subaru: like a woman who “yearns to be tamed”
Message Unclear: something about a postage meter and wanting to kill a woman

Is it always illegal to kill a woman?

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 primary role is cooking and house-keeping

fast forward 60 years

- The following ads convey with equal clarity a new set of messages about women

Today, women “serve” a different purpose. Women are used primarily to sell brand name widgets

This “little woman” of the house is no longer expected to be the 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 play toy

I can’t cook. Who cares?
Ad for French Fries: do you notice the french fries?

“real fries in a fake world”

A little oral sex with your 7 inch burger?

ad for Lynx Shower Gel

Ad for JBS Men’s underwear

even Nikon Camera

Ad for Legos?
implied adult sex advertising Lego brand toys for children
What are the Messages?

much simpler than the 1950’s

women are sex objects for use by men

What influence does this marketing blitz have on sexual assault?

objectification of women permits dehumanization

❖ Women’s roles in the 1950s:
✓ cooking / keeping the house
✓ bearing and raising the children
✓ Keeping your husband satisfied

❖ Women’s role by 2015:
✓ Sexual objects – pure & simple

the principle is pretty simple

• what we think, what we believe to be true – our beliefs – our attitudes
• 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 flaccid 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”

Vast majority of men would not take kindly to “reduced” to:

- The lack of a contoured stomach
- Too narrow shoulders
- Poorly defined chest & “pecs”
- A penis that just didn’t “stand-up” to expectation
- A face that was, well, shall we say, unmemorable, too round, too pudgy, too poorly proportioned
- And, 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 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 1 purpose: to be workhorses for women

2013, Steubenville, Ohio

- Two high school football players were found guilty of raping a 16-year-old girl in a case that attracted drew national attention, principally because social media revealed the utter depravity of the crime.
- There is no better example of dehumanization
The 16 year old victim was not a human being
• The only thing that defined her was secondary sexual characteristics of her body
• In the most extreme sense, she was treated 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”

“Love Dolls” are inanimate objects
• The 16 year old girl was drugged to unconsciousness, dragged naked from party to party, and raped repeatedly
• What degree of callous indifference and crass insensitivity is called upon to commit such a crime?
• She was not an inanimate object; she was a human being

these same attitudes

even find expression in the courtroom, and by politicians at the highest level

Judge Archic 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

Congressman Todd Akin (R-MO)

“If it's a legitimate rape, the female body has ways to try to shut that whole thing down.”

this is a United States Congressman speaking in 2012
Missouri Rep. Todd Akin defended his no-exceptions abortion policy by saying "legitimate rape" rarely causes pregnancy.

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)

Besides his ignorance, what is “legitimate” rape?

• Legitimate to who? Todd Akin? Who will stand in judgment of what crimes are “legitimate”?  
• For Todd Akin, it obviously is not the victim.  
• If YOU were the victim of an armed robbery, can you imagine being told by the police or by the court that “it was not a legitimate armed robbery”

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!”

Senate candidate Richard Mourdock (R-IN)

“Life is that gift from God. I think that even when life begins in that horrible situation of rape, that it is something God intended to happen.”

this is a candidate for the United States Senate speaking in 2012

• God intended for me to be raped? What kind of God would intend for me to be raped?

• God intended for you to be held up at knife point and have your wallet taken.

• Does that sound right?

Senate candidate Tom Smith (R-PA)

compared rape to having a baby out of wedlock, saying if you “put yourself in a father's situation.” “It’s a similar kind of thing.”

this is a candidate for the United States Senate speaking in 2012

All of these remarks were made shortly before the 2012 Presidential Election

• They are not just crude.

• They are not just ignorant.

• They are hostile towards women; they trivialize rape; they come close to legitimizing rape
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
- Conservative Heritage Action and FreedomWorks called VAWA: “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!

More Recently

- “Outrage over Sexist Remarks Turns into a Fund-Raising Tool,”
- article by Amy Chozick

- “In the last few months,
- Republicans have called:
- Wendy Davis, a Democratic candidate for governor in Texas “Abortion Barbie,”
- Likened Alison Lundergan Grimes, a Senate candidate from Kentucky, an “empty dress”
- Criticized Hillary Rodham Clinton’s thighs
- Referred to a pregnant woman as a “host”

Rock Musician Ted Nugent

- Campaigning for Greg Abbott, Republican candidate for Texas Governor:
- Referred to women as “fat pigs” and “worthless”
- Todd Akin referred to Senator Clair McCaskill as:
- “dog playing fetch in Washington”

- Do you recall any male politician being referred to as:
- an “empty suit”
- criticized for his pot belly? (did anyone dare comment on Chris Christie’s girth?)
- referred to a man as a “wuss” or a wimp?
- or scrawny?
Most Recently
state Rep. Steve Vaillancourt (R-NH)
October, 2014

Pronounced that that the D-incumbent was “too ugly to win”
This man has the audacity to talk about “too ugly”

“bordering on a misogynistic theater of the absurd”

- blogged on the House race in NH’s 2nd Congressional District between Republican Marilinda Garcia and Democratic incumbent Ann McLane Kuster.
  “Let’s be honest. Does anyone not believe that Congressman Annie Kuster is as ugly as sin? And I hope I haven’t offended sin. Annie Kuster looks more like a drag queen than most men in drag.”

Lessons Learned & Reified

- Young boys raised by fathers who are role models for demonstrating the basic tenets of “manhood,” by their own behavior in the way they treat their spouse and how they define their role as husband and father, by the “rules” they lay down and the “advice” and guidance they give to their son
- Youngsters connect with like-minded friends / peers as early as grammar school and on into high school who reify / reinforce what was heard / learned at home.

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 belittling and demeaning women, and objectifying women as nothing more than sexual objects for men’s use and pleasure

This is what is referred to as a “Rape Culture”

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 condones rape, tolerates of rape, and excuses rape by demeaning & belittling women
VIDEOS BY MODULE
BOLD DENOTES STARRSA PROJECT PRODUCED VIDEO

Module 2

SESSION 1
Possible Videos:
- Student discussion session with Dr. Abrams: What is sexual assault?
- Student discussion session with Dr. Abrams: Sexual assault statistics Part I
- 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

SESSION 2
- The Locker Room Video
- Student discussion session with Dr. Abrams: Consent Part I, II, III, 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 and II
• Student discussion session with Dr. Abrams: Sex and the Media Part I and II

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 and II
• Student discussion session with Dr. Abrams: Attitudes 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 and 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, II and 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)

SESSION 5
Possible Videos:
• Student discussion session with Dr. Abrams: Alcohol and sexual assault, Parts I, II, III, and 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
• The 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

SESSION 2

• Student discussion session with Dr. Abrams: Healthy Masculinity
• 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.
  o http://www.ted.com/talks/tony_porter_a_call_to_men?language=en
Module 6

SESSION 1 & 2

- Victim Perspective video
- Student discussion session with Dr. Abrams: Facts about sexual assault Part I and 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
- Student discussion session with Dr. Abrams: Consequences of reporting sexual assault Part II
- 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

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
- 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

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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

- 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, II, III, and 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
- 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
- Returning to Campus
STARRSA PROJECT 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

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**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 widespread 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 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 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 (i.e., intoxication or drug use) it should be assumed that consent for sexual activity can 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 behave 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 public’s 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.

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 have 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 discuss 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 frequency 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, 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 accountably 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 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 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. Imagine 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 false 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.

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**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.

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**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 at 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 caring 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 (i.e., intoxication or drug use) it should be assumed that consent for sexual activity can 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.

Student discussion session with Dr. Abrams: Alcohol and consent (also can be used in Module 2)

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.

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? 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 MULTIMEDIAL 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

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=6CB1wqXPCM0)

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=bhqT2JWwCC4

Consent, Explained by a Porn Star: A Consent Video by Buzzfeed  
https://www.youtube.com/watch?v=JEAqXMcj0w
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)

7 things that have nothing to do with rape perfectly illustrate the concept of consent (article included below)

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

Here’s Why We Need to Talk to Men About Violence Against Women

Rice Video Accelerates Cultural Shift on Men’s Violence
http://www.huffingtonpost.com/jackson-katz/rice-video-accelerates-cu_b_5812366.html

Safer Sex

Safer Sex for Bisexual People and Their Partners

Beating Around the Bush: Sexuality Information for Lesbian and Bisexual Women

Safe Partying and Safe Sex

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 E

- 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
                                      o  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).

<table>
<thead>
<tr>
<th>Limited</th>
<th>Moderate</th>
<th>Satisfactory</th>
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<td>1</td>
<td>2</td>
<td>3</td>
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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 F

- 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):

American Psychological Association- Division 12:
Empirically Supported Treatments
http://www.div12.org/psychological-treatments/
APPENDIX G CFC

- Sexual Misconduct Contributing Factors Checklist (CFC)

The CFC was designed for use by student conduct professionals after a student has been found responsible of sexual misconduct, to help guide recommendations or sanctions.
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, including 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. 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.

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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. Student with multiple protective factors, for whom their 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)**

Student Name: ____________________________

Person(s) Completing CFC:_____________________________________________________

Date Completed: __________________________

<table>
<thead>
<tr>
<th>INCIDENT ONLY CHARACTERISTICS</th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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<tbody>
<tr>
<td>1. Any non-consensual, non-contact sexual conduct such as unwanted sexual remarks</td>
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<td>2. Any verbal pressure to have sex stopping short of threatening physical harm</td>
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<td>3. Any verbal threats of physical harm directed at Complainant</td>
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<td>4. Any non-consensual sexual touching</td>
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<td>5. Any stalking of Complainant before or after incident</td>
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<td>6. Any non-consensual oral, anal, vaginal penetration by the penis, fingers or objects</td>
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<td>7. Were there multiple acts of penetration or more than one form of penetration within the same incident</td>
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<td>8. Any non-consenting sexual acts involving multiple perpetrators</td>
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<td>9. Any physical force, including use of body weight differences</td>
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<tr>
<td>10. Was the violence <em>gratuitous</em> (i.e. clearly exceeded what was minimally necessary to force sexual contact (i.e., commit the sexual misconduct)</td>
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<td>11. Did the violence level escalate (i.e., increase), such as kicking, punching, or choking, <em>in response to resistance</em></td>
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<tr>
<td>12. Any injury to Complainant such as bruises, abrasions or sprains</td>
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<td>13. Was the incident reported to local police (campus or community)</td>
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<td>14.</td>
<td>Did Complainant receive medical care</td>
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<td>15.</td>
<td>Was forensic evidence gathered via a &quot;rape kit&quot;</td>
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<thead>
<tr>
<th>PRIOR MISCONDUCT</th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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<tbody>
<tr>
<td>1.</td>
<td>Any prior reports of academic misconduct</td>
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<td>2.</td>
<td>Any prior reports of physical aggression (e.g., fighting)</td>
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<td>3.</td>
<td>Any prior reports of non-consensual sexual kissing, touching, groping or other contact sexual misconduct</td>
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<td>4.</td>
<td>Any prior reports of using threats of harm or physical force, even minimal, to coerce non-consensual, penetrative sexual acts</td>
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<tr>
<td>5.</td>
<td>Any prior reports of non-academic conduct violations other than those mentioned above</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ALCOHOL AND PEERS [BOTH]</th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Any pressure on Complainant to drink alcohol</td>
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<tr>
<td>2.</td>
<td><strong>Was Complainant intentionally given a spiked drink/drinks without Complainant’s knowledge</strong> <em>(e.g., evidence that respondent knowingly gave the Complainant a drink with drugs with the intent of facilitating sexual misconduct)</em></td>
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<tr>
<td>3.</td>
<td>Any pressure on Complainant to consume drinks spiked with other drugs</td>
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<tr>
<td>4.</td>
<td><strong>Did incident take advantage of an already intoxicated, stoned or otherwise incapacitated Complainant who was unable to consent</strong> <em>(e.g., Respondent committed the sexual misconduct knowing that the Complainant was impaired from drugs or alcohol)</em></td>
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<td>5.</td>
<td><strong>Was Complainant unconscious, passed out or asleep during all or some of the incident</strong></td>
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<tr>
<td>6.</td>
<td>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)*</td>
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<tr>
<td>IMPERSONAL BEHAVIORS [BOTH]</td>
<td>Yes</td>
<td>No</td>
<td>?</td>
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<tr>
<td>-----------------------------</td>
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<tr>
<td>1. Complainant was a stranger</td>
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<tr>
<td>2. Complainant was known or recognized and complainant did not have any prior consensual sexual activity with the respondent.</td>
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<tr>
<td>3. Any involvement in recording pictures/videos of the incident</td>
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<td>4. Any posting on Internet, or emailing/texting about the incident</td>
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<tr>
<td>5. Any remarks in which it seemed as if Respondent was conceited, bragging, boasting, or trying to impress the Complainant or other students/peers</td>
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<tr>
<td>6. Any remarks by Respondent to peers that suggested incident was viewed as a “sexual conquest”</td>
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<tr>
<td>7. Respondent evidences no concern for Complainant</td>
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<tr>
<td>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)</td>
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<tr>
<td>9. Respondent did NOT use a condom</td>
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<tr>
<td>10. Respondent typically chooses sex partners based primarily on sexual availability, without emotional or other attraction as selection criteria.</td>
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<thead>
<tr>
<th>HOSTILITY [BOTH]</th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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</thead>
<tbody>
<tr>
<td>1. Use of verbal coercion or pressure that was highly manipulative, e.g., implying that sex was “owed,” or an “obligation” or “expected”</td>
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<tr>
<td>2. Any statements during or after that blamed the Complainant, such as “you like this,” “you deserve this” or “you wanted this”</td>
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<tr>
<td>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</td>
<td></td>
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<tr>
<td>4. Any statements intended to demean or degrade the Complainant’s race, ethnicity, religion or personal characteristics (such as being overweight)</td>
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<tr>
<td>5. Verbal threats of harm directed at Complainant</td>
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</table>
6. **Respondent’s responses reflected general anger at the Complainant and/or the institution**

<table>
<thead>
<tr>
<th>POSSIBLE PROTECTIVE FACTORS</th>
<th>Yes</th>
<th>No</th>
<th>?</th>
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</thead>
<tbody>
<tr>
<td>1. Respondent appears to accept responsibility for the incident</td>
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<tr>
<td>2. Respondent is currently involved in counseling/therapy</td>
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<tr>
<td>3. Respondent expresses willingness to be in therapy around the current incident</td>
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<td>4. Respondent has a moderate to strong academic record</td>
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<tr>
<td>5. Respondent appears to express some genuine degree of regret, remorse or contrition</td>
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<tr>
<td>6. Respondent appears to associate with healthy peers that do not actively promote sexual conquest</td>
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</tbody>
</table>

**Contributing Factors Summary**

In the section below please provide an opinion about (1) the most salient concerns, (2) strengths (protective factors) and (3) other relevant information useful to understanding the student’s historic and current status. Please use the back of this form or attach a page if more space is needed.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Evaluator Signature: ________________________________

Date Completed: ________________________________

*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 H
RESOURCES FOR CLINICIANS

- Factsheets
  - What you need to know about campus sexual assault disclosure and reporting. Administrator Researcher Campus Climate Collaborative
  - What you need to know about campus sexual assault perpetration. Administrator Researcher Campus Climate Collaborative
  - What you need to know about campus sexual assault victimization. Administrator Researcher Campus Climate Collaborative
- Organizational websites
- Guidelines
Factsheets

[http://campusclimate.gsu.edu/files/2015/04/Facts-about-disclosure.pdf](http://campusclimate.gsu.edu/files/2015/04/Facts-about-disclosure.pdf)

*What you need to know about campus sexual assault victimization.*

*What you need to know about campus sexual assault perpetration.*
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


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/

Glossary TBA


Dissertation Abstracts International: Section B: The Sciences and Engineering, 54(7-B), pp. 3894.


Canan, S. N., Jozkowski, K. N., Crawford, B. L. (2016). Sexual assault supportive attitudes: Rape myth acceptance and token resistance in Greek and non-Greek college students from the two university samples in the United States. *Journal of Interpersonal Violence*


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Krahé, B., & Berger, A. (2013). Men and women as perpetrators and victims of sexual aggression in heterosexual and same sex encounters: A study of first year college
students in Germany. Aggressive Behavior, 39(5), 391-404. doi: http://dx.doi.org/10.1002/ab.21482


This resource was prepared by the author(s) using Federal funds provided by the U.S. Department of Justice. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.


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Reed, E., Prado, G., Matsumoto, A., & Amaro, H. (2010). Alcohol and drug use and related consequences among gay, lesbian and bisexual college students: Role of
experiencing violence, feeling safe on campus, and perceived stress. *Addictive behaviors, 35*(2), 168-171.


