Supportive Resources for Teaching Healthy Sexuality and Body Maturation During Trauma-Focused Cognitive Behavioral Therapy

Jennifer Davis

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Supportive Resources for Teaching Healthy Sexuality and Body Maturation During Trauma-Focused Cognitive Behavioral Therapy

by

Jennifer Davis

An Honors Capstone

submitted in partial fulfillment of the requirements

for the Honors Certificate

to

The Honors College

of

The University of Alabama in Huntsville

December 3, 2018

Honors Capstone Director: Ann Bianchi, PhD, RN
Associate Professor

[Signatures and dates]

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Jennifer Davis
Student Name (printed)

Jennifer Davis
Student Signature

12-03-2018
Date
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________________________________________________________________________
Director (signature) Date

________________________________________________________________________
Department Chair (signature) Date

________________________________________________________________________
Honors College Dean (signature) Date

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Student Signature

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Abstract

Background: Child sexual abuse affects a multitude of children in our society. It is important for professionals to have a working knowledge related to the roles of all disciplines. This is especially true for licensed therapists who have the longest lasting relationship with the child and will encounter many different scenarios and questions throughout therapy.

Methods: This study used a quasi-experimental pre-post test design using purposeful sampling. Participants were asked to complete the Pre-Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Questionnaire. Participants were then asked to use 12 different resource materials for a 4-month period during Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). Topics of the resource’s materials included: STTI information, safe sex, dating tips, body and sexual development, how babies are made, and pre-constructed scenarios.

Results: Eleven licensed therapist participated. Factor analysis revealed 2 subscales, knowledge level and comfort level. Subscale analysis for pre and post assessment revealed a significant improvement in knowledge \( p = .000 \), comfort level \( p = <.007 \). For the question regarding the Myths and Facts sheet 100% of the participants stated that it was helpful in use during therapy. For the question regarding Scenarios to be Used by Therapists When Meeting with Parents, 100% of participants stated that they found it helpful in use during therapy.

Conclusion: A multidisciplinary approach can be beneficial to both the nursing community and licensed therapists who work with children and parents during TF-CBT. Nursing has a lot to offer licensed therapists who conduct TF-CBT in terms of providing accurate and appropriate information related to healthy sexuality, body maturation, and body safety.
Introduction

According to the World Health Organization (WHO) child sexual abuse is defined as, “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society” (World Health Organization, 2003). In 2016, the CDC had record of 676,000 victims of child abuse and neglect that were reported to child protected services. It is estimate that 1 in 4 children experience some form of child abuse and neglect in their lifetimes and 1 in 7 children within the last year. A total of lifetime economic cost for child abuse and neglect is estimated to be $124 billion each year (Centers for Disease Control and Prevention, 2018). The vast number of children and families affected indicate that there is a need for all health care providers and licensed therapist who come in contact with children have training and knowledge in how to best assist without causing additional harm or confusion. This is especially true during the disclosure process when the child will come in contact with many different professionals.

Multiple disciplines have the need to interview a child sexual assault (CSA) victim upon disclosure of abuse. Without a common protocol, this can lead to multiple interviews with the child and re-traumatization to the child. Combining the medical and psycho-social approach to interviews is important to creating an effective multidimensional approach (Cheung & Boutte-Queen, 2010). A true interprofessional collaboration in which each area of expertise educates the others on the most up to date and pertinent language, information, and standards of practice would lessen traumatization of the child by decreasing the number of times the child must be asked the same questions in different ways. An example of this is training health care professionals how to best handle potential disclosures of CSA due the high incidence of this
occurring during treatment. Health care professionals should know how to form developmentally appropriate questions and create an atmosphere of trust when they suspect CSA in a clinical setting (Stavrianopoulos & Gourvelou, 2012). Another example is having health care professionals kept up to date by law enforcement prosecutor's expectations related to procedures of the forensic interview and examination. In fact, information gathered by the health care professional, by either physical or verbal means, can be very important to prosecution of the offenders. (Stavrianopoulos, 2012; WHO, 2003). Gibson & Lynn (2008), recommend health care professionals should be properly trained to communicate with a victimized child in order to prevent re-traumatization and to maintain legal verbal evidence. When children are asked to recall traumatizing situations, they may have physical stress effects that are similar to the original trauma (Gibson & Lynn, 2008). With this information in mind, it would appear equally as important that other disciplines could learn much from healthcare professionals regarding medical and anatomical terminology, sexuality related diseases with possible symptoms and treatments, and other physiologic areas of interest that are often encountered when working with victims of CSA.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one evidence based method for treating children and adolescents that have experienced trauma along with their caregivers (TF-CBT Therapist Certification Program, 2018). TF-CBT has the intended effect of reducing “negative emotional and behavioral responses following child sexual abuse…and other trauma” (Child Welfare Information Gateway, 2012). It also is used to help the non-abusive parents to cope with the situation and develop supportive skills for their child. One of the major components of TF-CBT is to promote personal safety and future growth in relation to healthy sexuality among other areas (2012). Health care professionals can support the therapist by
offering training and resources related to the physiological effects of child abuse in conjunction with information related to healthy sexuality from a bioeducational perspective.

**Review of Literature**

Several studies identified in the literature emphasized the importance of interdisciplinary training and the training of health care professionals to react and perform questioning during disclosure scenarios without causing further trauma to the child. One way to prevent re-traumatization is to implement a multidisciplinary interview protocol in which the child is only questioned once with a preset questioning form in which members of several disciplines (law enforcement, legal, medical, social workers, therapist) are present. This protocol is created with the input of all the disciplines and leads to less repeated questioning of the child causing less secondary trauma (Cheung & Boutte-Queen, 2010). In a 1990 evaluation of interdisciplinary training in intervention with victims of CSA it was shown that medical staff learned less from the training about physical indicators, but learned much about behavioral and psychological indicators of abuse. The evaluation also found that there was a significant increase in knowledge about physical indicators in the non medical staff, whereas the increase was not substantial in the psychological and behavioral changes. The training increased the amount of reports made by nonmedical staff significantly, which shows that there is a need for education in the nonmedical providers as well (Sullivan, 1990). Weerakoon, Sitharthan, and Skowronsiki, (2008) pointed out the consensus between the National Institute of Health (NIH) and the WHO that there is a need for increased education among health professionals about sexual matters and sexual health due to the health professions being “relatively uniformed or misinformed about sexual matters."
A 2002 study found that there is poor adherence to recommendations for follow up of care in victims of CSA. In this study medical follow up was recommended for 69% of patients and only 9% of the patient’s parents remembered the recommendation. In contrast to this, 79% of the parents of children recommended for therapy remembered this along with 37% of those not recommended for therapy that thought they were (Lane, Dubowitz, & Harrington, 2002). The stark contrast in these numbers puts the therapists in a position of being the primary, and often only, source of evaluation for the children. Having a knowledge base and comfort level to understand when medical issues are presented during therapy, even if indirectly, would allow the therapist to reinforce the recommendation of following up with a medical provider. It is important that the therapists present a comfortable exterior when discussing sexual issues. It has been shown that patients often do not discuss sexual matters or ask questions because they may embarrass the provider (Marwick, 1999).

Miller and Byers, (2009) identified there is a lack of knowledge and training in sexual matters which leads to a reluctance to ask about them during therapy. It also pointed out that though therapists are more likely to be asked about safe sexual practices they are more likely to search out information and training on specific sexual issues. Education helps to improve comfort level when dealing with a wide variety of sexual health issues (Weerakoon, Sitharthan, & Skowronsksi, 2008) and a vast majority of therapists verbalize a desire to increase their own education and comfort levels (Miller & Byers, 2009).

The purpose of this study was to evaluate the effectiveness of resources provided to licensed therapists at the National Children’s Advocacy Center (NCAC) when teaching healthy sexuality, body maturation, and body safety during trauma-focused cognitive behavioral therapy with children and parents (TF-CBT). This study aimed to answer the following research question:
Does the use of healthy sexuality, body maturation, and body safety resources increase knowledge and comfort level when teaching during trauma-focused cognitive behavioral therapy sessions with children and parents?

**Theoretical Framework**

Barker's Tidal Model of Mental Health Recovery revolves around a metaphor of water. It parallels pivotal life experiences with sea-life events. A life crisis is seen as a storm which can lead to drowning or a personal breakdown. The person may need a shelter to recover in that can be found in rehabilitation times. When the person is well again, one could say that they have recovered their "sea legs" (Barker, 2001). This theory takes a holistic view of how to care for patients in the mental health arena and has its foundations in a biopsychosocial model of mental health. Barker does not dismiss the biological aspect of mental health, but true to nursing, chooses to look at the patient as a whole. He understands that a person's life experiences directly affect disorders such as depression, anxiety, and others. This theory asserts that by acknowledging and treating the patient and his or her story, a patient may indeed enter full recovery. The Tidal Model argues that there are three dimensions of personhood: world, self, and others. A person's need to be understood falls into the dimension of world. Validation of a person's life crisis, such as a traumatic event or illness, falls into this category (Barker, 2001). A person's need for safety and security belong to the dimension of self. The others dimension includes any assistance or aid the patient may need to live a normal life. Examples can include basics such as housing and food, medication, or different forms of therapy (Barker, 2001).

**Methods**

**Research Design**
A quasi-experimental study using pre-post test design was used to evaluate the knowledge and comfort level when teaching healthy sexuality, body maturation, and body safety during TF-CBT with children and parents.

**Population, Sample and Setting**

The sampling method was purposeful and convenience sampling. The inclusion criteria for the study are as follows: the participant must be a licensed therapist that conducts TF-CBT with children and parents, be over the age of 18, all ethnicities, males and females, and have the full support of NCAC in using the resource packet during TF-CBT. The study was conducted at NCAC and NOVA where all TF-CBT session were held with children and parents.

**Measures**

Demographic data included age, gender, ethnicity, education level, years of counseling, years of conducting TF-CBT, and years of employment at the NCAC or NOVA. (See Appendix A).

The Pre-Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire was used to rate the participants knowledge and comfort level and effectiveness prior to using the resource materials during trauma-focused cognitive behavioral therapy sessions with children and parents. This questionnaire consisted of 20 questions using a 5 point Likert scale ranging from 1 (poor) to 5 (excellent) and 2 true false questions. (See Appendix B).

The Post Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire was used to measure the participants knowledge and comfort level and effectiveness after using the resource materials during trauma-focused cognitive behavioral therapy sessions with children.
and parents. This questionnaire consisted of 20 questions asking the participants to rate their knowledge and comfort level and effectiveness after using the resource materials during trauma-focused cognitive behavioral therapy sessions with children and parents using a 5-point Likert scale ranging from 1 (poor) to 5 (excellent), 4 true false questions, and 1 open-ended question. (See Appendix C).

**Procedure**

Following Institutional Review Board approval (See Appendix D) recruitment began at NCAC. Once the participant agreed to participate, they filled out a demographic form and completed the Pre-Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire. Each participant was given the Healthy Sexuality, Body Maturation, and Body Safety resource packet and asked to use this resource packet during TF-CBT sessions for a period of 4 months (See Appendix E). At the completion of the study the participants were asked to complete the Post-Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire.

**Results**

The final sample size consisted of nine participants. Demographic variables are shown in Table 1. Reported ethnicity include 66.7% (6) white and 33.3% (3) black. Of the nine participants 88.9% (8) were female and 11.1% were male. The participants’ ages ranged from 27 to 57 years, with an average age of 42. Their education level included 77.8% (7) had a masters degree, 22.2% had a PhD. For total years of licensed counseling 22.2% (2) reported less than one year, 33.3% (3) reported having between 1-4 years, 11.1% (1) reported having between five
to ten years, and 33.3% (3) reported having more than 10 years of licensed counseling
experience. For total years of experience working a NCAC 11.1% (1) reported less than one
year, 55.6% (5) reported having between 1-4 years, 11.1% (1) reported having between five to
ten years, and 22.2% (2) reported having more than 10 years of experience.

All participants reported having access to myths and facts related to healthy sexuality,
body maturation, and body safety enhanced conducting TFCBT would be helpful. Post
assessment indicated 9 participants (100%) reported having access to myths and facts related to
healthy sexuality, body maturation, and body safety enhanced conducting TFCBT would be
helpful. All participants also reported having access to scenarios related to healthy sexuality,
body maturation, and body safety enhanced conducting TF-CBT.

When asked if the participants felt the boy and girl diagrams were useful when
conducting TF-CBT 7 participants (77.8%) reported the diagrams were useful. One participant
did not respond to this question and one participant reported not using the diagrams.

Factor Analysis was conducted and 2 factors surfaced. These were knowledge and
comfort level.

A paired $t$ test was conducted to evaluate the Subscale for Knowledge Level. Alpha was
set at $p<.05$. There was an increase in scores for knowledge from the pre assessment ($M=33.33,
SD=.63$) to the post assessment ($M=4.18 SD=.64$), this was seen as statistically significant $t(8) =
-5.76, p=<0.000$(two-tailed). The mean increase for knowledge level was .87 with a 95%
confidence interval ranging from -1.19-.51
A Wilcoxon was conducted to evaluate the Subscale for Comfort level. The $p=0.007$, which indicates a statistically significant difference has been detected between the pretest and the posttest.

**Limitations**

Limitations in this study included small sample size, one site used to conduct the study, and the measurements used to evaluate the effectiveness of resources provided to licensed therapists were investigator derived. Any further study should include multiple locations for recruitment and a larger sample size. The measurement instrument should also be assessed further for validity.

**Discussion**

The purpose of this study was to evaluate the effectiveness of resources provided to licensed therapists at the National Children’s Advocacy Center (NCAC) when teaching healthy sexuality, body maturation, and body safety during trauma-focused cognitive behavioral therapy with children and parents (TF-CBT). This study indicated there was an increase in knowledge and comfort level when resources are provided to licensed therapist to use during TF-CBT. The findings correlate with previous research that indicates the desire of licensed therapists to learn more about sexuality and how to best discuss these topics with their clients (Miller & Byers, 2009). There is also a relationship between the increase of knowledge and the increase of comfort level that is shown but is not measured in this study. This supports previous research that indicates a correlation between knowledge and comfort levels when discussing healthy sexuality with clients (Weerakoon, Sitharthan, & Skowronski, 2008).

**Implications to Nursing Practice**
Nursing has long been a profession of education. Nurses educate each other, the community, and their patients. This study shows that there is a benefit for the education of other disciplines by the nursing community and for an increase in collaborative care between licensed therapists and nurses. In any discipline the increase in knowledge pertaining to other disciplines will not only promote a better understanding and encourage collaboration but has the potential to increase the health and well-being of all individuals in the community.

Conclusion

The statistical significance of this study reflects there was a need to provide supportive educational materials to licensed therapists related to healthy sexuality and body maturation. It would be interesting to see if future studies with a larger sample size if a different set of subscales would become evident related to a larger increase in knowledge related to the biophysical side of sexuality in comparison to the psychosocial side of sexuality.

This study points to the beneficial relationship between nursing and licensed therapists in interdisciplinary collaboration. The knowledge of one clinical subgroup can be used to strengthen the skills of another clinical subgroup. Future studies are needed to validate the measurements used in this study and build a reliable instrument that measures knowledge and comfort level with the topics in the resource materials.

Dissemination of Scholarly Work

The study was presented at the Research and Creative Experiences for Undergraduates (RCEU) poster presentation at The University of Alabama in Huntsville in August 2018. (See Appendix F). A proposal was submitted and accepted for an oral presentation for the 18th
Annual University of Alabama System Honors Research Conference in November 2018 (See Appendix G).

This study has also gleaned the attention from the Clinical and Intervention Director at NCAC and an invitation to conduct an oral presentation at the 35th International Symposium on Child Abuse March 2019 has been accepted (See Appendix H).
References


Table 1: Demographics

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Appendix A

Participant Demographics

Please fill out the following information as part of your participation in the Supportive Resources for Teaching Healthy Sexuality and Body Maturation During Trauma-Focused Cognitive Behavioral Therapy study.

1. Age: _________

2. Gender: M_____ F_____

3. Ethnicity:
   ______ White
   ______ Black
   ______ Asian or Pacific Islander;
   ______ American Indian, Alaska Native
   ______ Spanish or Hispanic

4. Education level:
   ______ Baccalaureate degree
   ______ Masters degree
   ______ PhD

5. Years of licensed counseling experience: <1yr_____ 1-4yrs_____ 5-10yrs_____ >10yrs_____

6. Years of conducting TF CBT with children and parents: <1yr_____ 1-4yrs_____ 5-10yrs_____ >10yrs_____

7. Years of experience NCAC: <1yr_______ 1-4yrs_______ 5-10yrs_______ >10yrs_______
Appendix B

**Pre-Assessment** of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire

Participant Code number: ____________

**Pre-Assessment** of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire

**Directions:** Please complete this questionnaire prior to the use of the supportive resources for teaching Healthy sexuality and body maturation during TF CBT

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<tr>
<th></th>
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<th>fair</th>
<th>good</th>
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<td>7</td>
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</table>

1. How do you rate your knowledge level discussing healthy sexuality during TFCBT?
2. How do you rate your comfort level discussing healthy sexuality during TFCBT?
3. How do you rate your knowledge level discussing body maturation, during TFCBT?
4. How do you rate your comfort level discussing body maturation, during TFCBT?
5. How do you rate your knowledge level discussing body safety during TFCBT?
6. How do you rate your comfort level discussing body safety during TFCBT?
7. How do you rate your knowledge level discussing dating safety during TFCBT?
<table>
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<th>8</th>
<th>How do you rate your comfort level discussing dating safety during TFCBT?</th>
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<td>9</td>
<td>How do you rate your knowledge level discussing STIs</td>
</tr>
<tr>
<td>10</td>
<td>How do you rate your comfort level discussing STIs?</td>
</tr>
<tr>
<td>11</td>
<td>How do you rate your knowledge level discussing birth control methods?</td>
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<td>12</td>
<td>How do you rate your comfort level discussing birth control methods?</td>
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<td>13</td>
<td>How do you rate your knowledge level when using appropriate terminology related to body parts and body maturation?</td>
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<td>14</td>
<td>How do you rate your comfort level when using appropriate terminology related to body parts and body maturation?</td>
</tr>
<tr>
<td>15</td>
<td>How do you rate your knowledge level when initiating difficult conversations related to healthy sexuality, body maturation, and body safety resources?</td>
</tr>
<tr>
<td>16</td>
<td>How do you rate your comfort level when initiating difficult conversations related to healthy sexuality, body maturation, and body safety resources?</td>
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<td>17</td>
<td>How do you rate your knowledge level discussing body and sexual development during puberty?</td>
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<td>How do you rate your comfort level discussing body and sexual development during puberty?</td>
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<td>19</td>
<td>How do you rate your <em>knowledge level</em> discussing how babies are made?</td>
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<tr>
<td>20</td>
<td>How do you rate your <em>comfort level</em> discussing how babies are made?</td>
</tr>
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<td>21</td>
<td>Do you feel having access to <strong>myths and facts</strong> related to healthy sexuality, body maturation, and body safety will enhance conducting TFCBT?</td>
</tr>
<tr>
<td>22</td>
<td>Do you feel having access to more <strong>scenarios</strong> related to healthy sexuality, body maturation, and body safety will enhance conducting TFCBT?</td>
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</table>
Appendix C

Post Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire

Participant code number: __________

**Directions:** Please complete this questionnaire following the use of the supportive resources for teaching Healthy sexuality and body maturation during TF CBT over the last 10 Weeks

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<td>Did you feel having access to more <strong>scenarios</strong> related to healthy sexuality, body maturation, and body safety enhanced conducting TFCBT?</td>
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<td>Please offer any suggestions or recommendations for improving these resources.</td>
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Appendix D

IRB Approval Letter

April 30th 2018
Jennifer Davis
Department of Nursing
University of Alabama in Huntsville

Dear Ms. Davis,

The UAH Institutional Review Board of Human Subjects Committee has reviewed your proposal, Supportive Resources for Teaching Healthy Sexuality and Body Maturation during Trauma Focused Cognitive-Behavioral Therapy, and found it meets the necessary criteria for approval. Your proposal seems to be in compliance with this institution's Federal Wide Assurance (FWA) 00019998 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Please note that this approval is good for one year from the date on this letter. If data collection continues past this period, you are responsible for processing a renewal application a minimum of 60 days prior to the expiration date.

No changes are to be made to the approved protocol without prior review and approval from the UAH IRB. All changes (e.g. a change in procedure, number of subjects, personnel, study locations, new recruitment materials, study instruments, etc) must be prospectively reviewed and approved by the IRB before they are implemented. You should report any unanticipated problems involving risks to the participants or others to the IRB Chair.

If you have any questions regarding the IRB's decision, please contact me.

Sincerely,

Bruce Stallsmith

Expedited (see pg 2)
Exempted (see pg 3)
Full Review
Extension of Approval
Expedited:

☐ Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review. (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

☐ Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).

☐ Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

☐ Collection of data from voice, video, digital, or image recordings made for research purposes.

☐ Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Exempt

☐ Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods. The research is not FDA regulated and does not involve prisoners as participants.
Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interviews, or observation of public behavior in which information is obtained in a manner that human subjects cannot be identified directly or through identifiers linked to the subjects and any disclosure of the human subject’s responses outside the research would NOT place the subjects at risk of criminal or civil liability or be damaging to the subject’s financial standing, employability, or reputation. The research is not FDA regulated and does not involve prisoners as participants.

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement) survey procedures, interview procedures, or observation of public behavior if (a) the human subjects are elected or appointed public officials or candidates for public office, or (b) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter. The research is not FDA regulated and does not involve prisoners as participants.

Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. The research is not FDA regulated and does not involve prisoners as participants.

Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs. The protocol will be conducted pursuant to specific federal statutory authority; has no statutory requirement for IRB review; does not involve significant physical invasions or intrusions upon the privacy interests of the participant; has authorization or concurrent by the funding agency and does not involve prisoners as participants.

Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. The research does not involve prisoners as participants.

Surveys, interviews, or observation of public behavior involving children cannot be exempt.
Appendix E

Supportive Resources

I. Terminology

Subheading: Sexual behavior

Coercion – “Non-physically forced penetration which occurs after a person is pressured verbally, or through intimidation or misuse of authority, to consent or submit to being penetrated” (1)

Child pornography - any visual depiction of sexually explicit conduct involving a minor (persons less than 18 years old) (2)

Inability to consent – “A freely given agreement to have sexual intercourse could not occur because of the victim’s age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated (e.g. incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs” (1)

Inability to refuse – “disagreement to engage in sexual contact was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority” (1)

Noncontact sexual abuse – “sexual violence that does not include physical contact of a sexual nature between the perpetrator and the victim. Examples include unwanted exposure to sexual situations (pornography, voyeurism), sexual harassment, unwanted filming, and more” (1)

Oral sex – “the use of the mouth to stimulate another person’s genitals” (7)

Rape – “physically forced or otherwise coerced penetration – even if slight – of the vulva, anus, using a penis, other body parts, or an object” (3)

Sexual consent – “words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact” (1)

Sexual violence – “A sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse” (1)

Sexting – “Sexting refers to an act of sending sexually explicit materials through mobile phones. The word is derived from the combination of two terms sex and texting” (4)

Stalking – “a pattern of repeated and unwanted attention and contact that causes fear or concern for one’s own safety or the safety of someone else (e.g., family member or close friend)” (1)
**Unlawful sexual contact** – “a crime that varies state to state but is typically defined as when a person motivated by sexual gratification intentionally has sexual contact with another person who is less than a certain age or whose ability to consent is impaired, or causes the victim to have sexual contact with the person or a third person” (5)

**Subheading: Body maturation**

**Ejaculation** – “the propulsion of semen from the male duct system that occurs during male orgasm” (6)

**Erection** – “enlargement or stiffening of the penis that results from engorgement of the erectile bodies with blood” (6)

**Menarche** – “the first menstrual period” (6)

**Menstruation** – “the periodic, cyclic discharge of blood, secretions, tissue, and mucus from the mature female uterus in the absence of pregnancy” (6)

**Orgasm** – “a generally pleasurable sensation that occurs during sexual climax which produces rapid contractions of the muscles in the genital and anal area and, for some humans, throughout the body” (8)

**Pre-ejaculatory fluid** – “a gelatinous seminal fluid that helps lubricate the urethra for spermatozoa to pass through and to flush out and residual urine or foreign matter that might decrease sperm viability” (9)

**Vaginal Sex** – “sexual intercourse where a man’s penis is inserted into a woman’s vagina” (7)

**Wet Dreams** – “ejaculation that occurs spontaneously as a nocturnal emission” (10)

**Cervix** – “lower outlet of the uterus extending into the vagina” (6)

**Ovaries** – “the female reproductive organs in which ova (eggs) are produced; female gonad” (6)

**Penis** – “the male organ of copulation and urination” (6)

**Scrotum** – “the external sac enclosing the testes” (6)

**Semen** – “the fluid mixture containing sperm and secretions of the male accessory reproductive glands” (6)

**Sperm** – “the male gamete” (6)

**Testicles** – “male primary reproductive organs that produce sperm; male gonad” (6)

**Uterus** – “a hollow, thick walled organ that receives, retains, and nourishes fertilized egg; the site where an embryo/fetus develops” (6)
Vagina – “a thin-walled tube extending from the cervix to the body exterior; often called the birth canal” (6)
II. Myths and Facts

A. Myth: Childhood sexual abuse is linked to delayed onset age of menstruation.

    Fact: Childhood sexual abuse is actually linked to early onset age of menstruation. The more severe the abuse, the higher the likelihood of early onset occurring.

B. Myth: You can’t get pregnant if the male pulls out.

    Fact: Pregnancy is possible even when using the “pull-out” method. A male begins releasing pre-ejaculation fluid once he is aroused. This fluid is filled with sperm that could fertilize an egg and cause pregnancy.

C. Myth: A female cannot get pregnant if it is her first time to have sexual intercourse.

    Fact: Every time there is sexual intercourse pregnancy is possible.

D. Myth: If you have sex in a hot tub you cannot get pregnant.

    Fact: Water of any kind (pool, hot tub, bath) does not prevent pregnancy.

E. Myth: You can get STIs from a toilet seat.

    Fact: Though this is theoretically possible, it is not probable or even remotely likely. The bacteria and viruses that cause STIs do not live outside of the human body for very long so they would most likely already be dead by the time anyone else used the toilet that was contaminated. If by some chance a person was to rub an open wound or mucous membrane against someone else’s fluids on the seat within seconds of it being left, then there would be a very small opportunity for infection.

F. Myth: All females will bleed the first time they have sex.

    Fact: The reason females can bleed during their first sexual intercourse is due to the rupture of the hymen. There are other ways that the hymen can rupture that have no sexual context at all such as horseback riding, cycling, or any other activity that could cause trauma to that area.

G. Myth: You cannot get an STI from oral sex.

    Fact: An STI can result from any form of sexual contact. Some STIs (such as herpes) can be transmitted from mouth to genitals or vice versa.

H. Myth: If I have only had sex with one person I cannot have an STI.

    Fact: If you have only had sex with one person, but that other person has had multiple sexual partners you could contract an STI.

I. Myth: I will be able to visually tell if my partner has an STI.

    Fact: Many STIs are have no visual symptoms or may be in a latent stage that is still contagious.
J. **Myth:** Using two condoms will prevent pregnancy / STIs better than one.

   Fact: Using two condoms actually increases the risk of both condoms breaking. This leads to an increased risk of pregnancy or STI.

K. **Myth:** The birth control pill will protect against STIs as well as pregnancy.

   Fact: The birth control pill only protects against pregnancy if taken exactly as prescribed. It has no protection against STIs. The best protection is consistent, concurrent use of hormonal contraceptives and condoms.

L. **Myth:** Only homosexuals or IV drug users contract and spread HIV.

   Fact: HIV is spread through blood and certain body fluids such as seminal fluid, breast milk, vaginal fluid, and rectal fluid. It doesn’t matter what race or class you belong to. The disease can be transmitted by these methods to anyone.

M. **Myth:** Antibiotics and other medication do not interfere with oral contraceptives.

   Fact: Some antibiotics can decrease the efficacy of oral contraceptives.

N. **Myth:** Smoking does not affect my use of birth control.

   Fact: Smoking increases the risk of blood clots in women of any age who are using hormonal forms of birth control. This can lead to conditions such as deep vein thrombosis (DVT) and stroke.

O. **Myth:** If I am sending or receiving sexually explicit pictures of myself or my girlfriend/boyfriend I won’t be in trouble as long as I am also a minor.

   Fact: You can actually be charged with distribution or possession of child pornography in the United States anytime sexually explicit pictures of a minor are distributed or possessed.

P. **Myth:** As long as both parties are consenting to sexual acts, it does not matter what the age of the participants are.

   Fact: According to Alabama state law, the age of consent is 16 and there is an age gap provision of 2 years. Both parties must be over the age of 12 to legally consent no matter what the age gap is. These laws vary from state to state.

Q. **Myth:** I am not a virgin if I was sexually abused.

   Fact: Virginity means different things to different people. Many people believe that there must be consent for virginity to be lost. The most important thing is what you believe and how you feel about your body.

R. **Myth:** I can’t have babies in the future if I was sexually abused.
Fact: It is possible to have children in the future even with the history of sexual abuse. However, research has shown that there may be a link to childhood adversity and increased rates of fertility problems in women.

(References: 2, 14, 15, 16, 22)
III. Sexually Transmitted Diseases

A. Chlamydia is a bacterial STI that is often asymptomatic in men and women which may cause many different types of complications in women. These include Pelvic Inflammatory Disease, ectopic pregnancy, and infertility.

1. Diagnosis can be made by testing 1st catch urine or collecting swab specimens from the endocervix or vagina.

2. **Treatment** is a course of antibiotics, most commonly Azithromycin or Doxycycline.

B. Herpes can occur in many forms. Genital herpes is a chronic, lifelong viral infection that results in lesions in the genital area. The first outbreak is the worst and is associated with severe genital ulcerations and neurologic involvement. As the disease continues, the frequency and severity of outbreak will lessen. Genital herpes is spread through sexual contact and the carrier does not have to be symptomatic to transmit the disease.

1. Diagnosis can be made by cell culture and PCR in patients with active lesions. In persons without active lesions, serologic testing is available. The HSV-2 tests are usually accurate, especially after a few weeks of infection. The HSV-1 serologic tests are of less value in asymptomatic persons due to the inability to distinguish the anogenital form from the orolabial or cutaneous infection.

2. **Treatment** of HSV is usually case specific with antiviral therapy. When a person has recurrent infections that are frequent suppression therapy with antivirals can be provided.

C. Syphilis is a systemic disease caused by *Treponema pallidum*. Transmission of this disease is thought to occur only when lesions are present. There are three stages of syphilis according to how the disease progresses and symptoms that are acquired. In primary syphilis there are ulcers or chancres at the site of infection. These are usually only present for up to 1 year. Secondary syphilis manifests as a skin rash, lesions around the body orifices (lips, vagina, anus, etc.) and swollen lymph nodes. Tertiary syphilis includes cardiac, lesions of the organs, bone, or other tissues, abnormal gait from and infection in the spinal cord, and partial paralysis from infection in the brain. The early neurological signs such as meningitis, stroke, cranial nerve dysfunction, etc. occur within the first few months to years of the disease. The late neurological changes occur after 10-30 years of untreated syphilis.

1. Diagnosis is made by swabbing the lesions if present or by blood testing in latent periods.

2. **Treatment** is antibiotic therapy, most notable penicillin.

D. HIV stands for Human Immunodeficiency Virus. Infection with this virus first presents with a short lived antiretroviral syndrome This occurs within the first few weeks of infection and
includes malaise, fever, rash, and lymphadenopathy. This continues into a chronic and lifelong illness that progresses into AIDS. HIV is spread through contact with infected blood and body fluids. This is most commonly associated with sexual contact or injection from a “dirty” needle.

1. Diagnosis is made by a series of blood tests and assays.

2. **Treatment** is complicated and multifaceted. Most notably there will be treatment with several different antiretroviral medications. Treatment is also related to preventing and treating infections due to the reduced ability of the immune system to fight on its own.

E. **HPV** stands for Human Papillomavirus. There are over 100 different HPV virus strands, many of which cause infection. There are high risk and low risk strands. The low risk strands can result in genital warts and respiratory problems. The high-risk virus strands have a link to cervical, vulvar, vaginal, penile, anal, and oropharyngeal cancers.

   1. There is testing for HPV, however it is usually only used in relation to abnormal cervical cytology or histology. Pap smears are used to test for pre-cancerous lesions in women. Macroscopic (visible) genital warts are treated when seen.

   2. **Treatment** is the use of antiviral medications. It is important to know that there are now vaccinations that prevent against many strains of HPV.

F. **Gonorrhea** is an STI that can cause significant urethral infections in males but is often asymptomatic in females until complications occur. The complications include infertility and ectopic pregnancy.

   1. Diagnostic testing is performed by either vaginal, endocervical, or urethral swabs in women. In men, a urethral swab is used.

   2. **Treatment** includes cephalosporin antibiotic therapy in conjunction with either azithromycin or doxycycline. The dual treatment is due to increasing bacterial resistance to treatment.

G. **Trichomonas** is a sexually transmitted infection caused by infection with a protozoan parasite. This infection is often asymptomatic for months to years after contraction. When symptoms do occur, they are noticeable. Men may experience infection or inflammation in the urethra, epididymis (a coiled tube behind the testicle), or prostate. Women will present with diffuse vaginal discharge that is yellow-green, malodorous, and may include vulvar irritation. This is the most prevalent non-viral STI in the US.

   1. Diagnosis occurs with a vaginal, endocervical, or urine specimen from men or women.

   2. **Treatment** is a course of antibiotics. Most commonly prescribed is Metronidazole.
Vaginal Infections Not Caused by STIs

H. Vulvovaginal Candidiasis is better known as a yeast infection. Typical symptoms are itching, abnormal vaginal discharge, soreness of the vaginal and vulvar area, pain or difficulty urinating, or pain during sex. There isn’t always a reason, but it is often opportunistic and presents in the absence of normal bacterial flora. This happens often after certain antibiotic treatments.

1. Diagnosis is based on clinical symptoms, cultures, and wet mounts.
2. Treatment is usually a short course of antifungal medications such as Miconazole.

I. Bacterial Vaginosis is a syndrome that is caused by the replacement of the natural flora of Lactobacillus sp. with a variety of other microbes. Most women present with vaginal discharge or malodor, but many are often asymptomatic. BV is associated with many things, but there is no known single cause.

1. Diagnosis is made with clinical symptoms or a gram stain. Sometimes both are used.
2. Treatment is recommended in women that are symptomatic. The most common treatments are Metronidazole and Clindamycin.

Reference: CDC 2015 Sexually Transmitted Diseases Treatment Guidelines (11)

(Centers for Disease Control and Prevention, 2017)
IV. Safe Sex (Forms of birth control)

Abstinence – This is complete nonparticipation in sexual activity. It is the only form of birth control and STI prevention that is 100% effective.

A. Condoms – There are two types of condoms, internal and external.
   - External condoms (male condoms)
     - Used to cover an erect penis and collects the semen after ejaculation.
     - These are considered between 85% to 98% effective for preventing pregnancy and are very effective in preventing the spread of STIs.
     - External condoms should be used in conjunction with a lubricant of some sort to prevent breakage and should never be used in a “double-bagging” method. Using more than one condom at a time can lead to breakage or tearing of the condom.
   - Internal condoms (female condoms)
     - Inserted inside of a woman’s vagina and is held in place by the one of the soft rings that are at either end of the device. The other end is left outside of the vagina and partly covers the labia.
     - Female condoms are considered 79% to 95% effective in preventing pregnancy and are also considered highly effective in preventing STIs.

B. Spermicides
   - There are many different types of spermicides that have the same action against pregnancy. They are chemicals that are inserted deep into the vagina with the intent of slowing or killing sperm before it can move past the cervix.
   - Spermicides are available in creams, gels, foams, suppositories, and film.
   - They are not effective at all against STIs and are only 70%-80% effective when used alone against pregnancy. However, the effectiveness rates increase if used in conjunction with a condom, diaphragm, or cervical cap.

C. Cervical Cap
   - A cervical cap is a small device that fits over the cervix. It is made of a soft latex rubber and comes in many sizes.
   - A cervical cap must be fitted by a healthcare provider and placement should be checked after insertion and before every instance of intercourse. It is held in place by suction and prevents sperm from entering the uterus when used in conjunction with spermicide.
   - It is not useful in the prevention of STIs.
   - If a woman has a birth, miscarriage, or weight loss/gain of 10 pounds or more she should be refitted for another cervical cap.

D. Oral Contraceptive (Pill)
   - The birth control pill can be composed of either one or two different hormones that are used to stop ovulation, thicken the cervical mucous, thin the lining of the uterus, or any combination of the three.
   - The pill must be taken every day at the same time for as long as the woman does not want to become pregnant.
   - The pill does not protect against STIs.
- The effectiveness rate is between 91-99%.
- The pills or other birth control methods that are combined hormone have a risk of blood clots and should not be used in women that have a history of inappropriate clotting. Smoking also increases the risk of blood clots.

E. **Contraceptive Patch / NuvaRing**
- The patch and the ring work in the same way as the pill, but instead of taking it daily the patch or ring is applied and worn for the first 3 weeks. After that the patch or ring is removed for 1 week during which the woman has her menses. The patch is reapplied on the first day of the menses for the patch or on day 7 after removal for the ring.
- They both have effectiveness rates of between 91% and 99%.
- Neither the ring or the patch prevents STIs.

F. **Depo-Provera**
- Depo-Provera is an injectable long acting birth control that is repeated every 12 weeks.
- It is effective 97-99% of the time.
- It does not prevent against STIs.
- This form of birth control, or any other progestin only hormonal control are recommended for women that are breast feeding or who for any other reason cannot have estrogen.

G. **Implanon**
- Implanon or Nexplanon is a tiny thin rod that is implanted under the skin in the upper arm. It releases the hormone Progestine and can be left in effectively for up to 4 years.
- It does not protect against STIs.
- Implanon is over 99% effective in preventing pregnancy.

H. **Intrauterine Device (IUD)**
- An IUD is a T shaped device that is placed at the entrance to the uterus by a healthcare provider. IUDs can be copper or progesterone based.
- Copper IUDs last from 3-10 years and the progesterone IUDs last from 3-5 years.
- They are both over 99% effective in preventing pregnancy.
- Neither is effective in the prevention of STIs.

(References: 12, 13)
V. Body and Sexual Development During Puberty

A. Females:

1. Breast development
   - Development of breast buds and areolar enlargement.
   - Development of secondary mound that is formed by the areola and nipple.
   - Areola recedes into the general shape of the breast leaving the nipple in a more projected state.

2. Hair development
   - Begins as long, straight, light colored hair along the labia.
   - Hair begins to appear under the arms as well.
   - Hair becomes dark, curly, coarse, and is lightly spread over the pubis.
   - Hair becomes more coarse, curly, and thicker but is still restricted to the area of the pubis.
   - Hair stays the same but spreads to the inner thighs.

3. Menstruation
   - Usually occurs about 2 years after breast bud development.
   - Around the same time as breast bud development there may be an increase of vaginal discharge that occur as the uterus prepares for menstruation.
   - Usually light and irregular for the first 6 months to 1 year of menstruation.
   - Average age for onset is 10.5 to 15.5 years.

4. General body development
   - There is a marked development in height, weight, and muscle mass during puberty.
   - There is a larger and longer development of fat mass than muscle mass.
   - The fastest rate of height growth is 6-12 months before the onset of menstruation. There is usually very little (less than 2cm) height growth after that.

B. Males

1. Hair development
   - Begins as slight amount of long straight hair at the base of the penis.
   - Hair begins to develop under the arms as well.
   - Hair becomes dark, curly, and coarser. It is thinly spread across the pubis.
   - Hair becomes thicker but is still only present in the pubic area.
   - Hair is an abundance of hair across the pubis and there is some on the inner thighs.

2. Scrotum and Penis
   - Begins with an enlargement of the testes and scrotum. There is reddening and a change in skin texture of the scrotum.
   - The penis becomes longer and the scrotum and testes continue to grow.
   - The penis grows wider and there is development of glans. The scrotum darkens in color.
   - The scrotum, testes, and penis become adultlike in appearance.
3. General Body Development

- There is a marked development in height, weight, and muscle mass during puberty.
- Muscle mass increases throughout puberty, but fat mass stops accumulating very early on.
- The largest amount of growth occurs after the onset of pubic hair and axillary hair development. Growth usually stops around the age of 18-20.

(Reference: 10)
VI. How Babies are Made

A. A man and a woman are attracted to one another and that makes them have feelings in their body. These feelings are caused by chemicals or messengers in the body called hormones. Sometimes this causes the man and woman to want to kiss or touch each other. The kissing and touching makes their bodies feel very good. Sometimes this leads to sex. When a man and a woman have sex, the man puts his penis inside of her vagina. If the man ejaculates inside the woman’s vagina his sperm can swim and meet her egg. Sometimes this can cause a baby to grow inside the woman’s belly. When a baby is growing inside the mom it is called pregnancy.

*Feelings and desires (hormones) leads to Kissing leads to Touching leads to Sexual Activity.

B. Baby grows – While the baby is in mom’s belly it grows a lot! There are three trimesters during pregnancy. This means that the time that a mom is pregnant is divided up by about 3 3-month periods. It takes a lot of time to grow a baby!

- First 6 weeks – The spinal cord and brain are developed. The heart and blood cells are also already developing. This is usually before the mom even knows she is pregnant!
- 1st trimester – Most of the organs are beginning to be developed and are growing! They are in the beginning stages. The baby is growing very fast during this time, but it is still too small to see or feel in mom’s belly.
- 2nd trimester – During this time the organs inside the baby are continuing to develop and grow. The baby is getting bigger and is starting to look like a person! At the end of this trimester mom can usually feel the baby move and sometimes you can too if you put your hand on her belly!
- 3rd trimester – In this trimester the baby has all of its body parts. It is just growing and getting big enough to come live in the outside world. The baby is moving a lot and mom’s belly is getting big to make room for it! It is almost time to be born!

C. Birth – the baby comes out of the mom during birth. Sometimes the baby comes out of her vagina and sometimes a doctor has to cut the mom’s stomach open and take the baby out. Either way, it is a very exciting time and everyone wants to meet the baby!

D. Mom and baby hug – After the baby is born the doctor will put the baby on the mom’s chest so she can cuddle with it. The baby loves its mom already and feels very safe when mom is holding it.

E. Mom feeds baby – A baby cannot eat food at all and can only drink milk. Sometimes the mom feeds the baby from her breast. This is called breastfeeding. Sometimes the mom feeds the baby milk from a bottle. If the milk does not come from mom, it comes from a store. This type of milk is called formula. The most important thing is for the baby to be fed so that it can grow and stay healthy.
VII. Effective Listening Tips for Parents
Effective Listening is an important part of communication and is a skill that can be learned. Listening effectively leads to a better understanding of what someone is saying and allows the listener to respond in a way that conveys respect and acceptance. Active listening involves being tuned to what the other person is saying, both verbally and nonverbally.

Tips for parents:

**Listen first:**
- Listen to better understand what your child is saying
- Use nonverbal skills to show you are supportive such as:
  - use eye contact
  - be aware of body language and body posture, uncross arms,
  - nod your head and have a positive facial expression
- When child stops talking pause to allow them time to continue
  - don’t jump in
  - this encourages to child to think over what was just said and gives time to convey new information
- Clarify what you have heard by paraphrasing
  - may say "I think I hear you saying ....... then repeat their words
  - may say "I think you are saying .............
- Encourage more discussion
  - ask open-ended questions to get more information
  - verbally encourage them to continue such as saying "mmm.mm", "I see", "oh", "OK"

**Respond second:**
- Process appropriately without judgment, scolding, or threats of punishment.
- Be supportive and open to accepting any information the child is offering regardless of content or circumstance. The child may need a disclaimer that disclosing will not lead to punishment.
- Assist child with problem solving, allowing the child discover reasonable responses to the situation or circumstance.
- Be prepared to not enforce punishment after the child discloses as they have come to you for support or help. This will help build trust.
- Thank your child for coming forward and praise them for talking to you as this will encourage them to come forward in the future. This also builds trust.
- Know you are not accepting the behavior but helping them have a better understanding of the consequences that may be life altering. You are helping them resolve conflict and educating them for preventative purposes. This will laying a foundation for open communication and trust so they will reach out for your support in the future.
VIII. Initiating Difficult Conversations with Your Children

A. Tell me what makes you feel sad, scared, happy, excited…….

B. Let’s talk about what made you sad that day or in that situation….

C. I am going to ask you some questions about your body, I am going to use terms, or names, of the body parts that are appropriate for that part of your body.

D. I have some questions to ask you that I ask everyone. It will help me to understand what is going on with you. It is important that you are honest with me.

E. If I say a word you do not know just tell me and I can explain. You can tell me what you call it and I can tell you what the proper name is.

F. We need to talk about some things that are happening (or are going to happen) with your body. These are things that happen to everyone as they grow up and there is nothing to be ashamed of. Your body is just changing and growing in the way that it should. This is part of becoming an adult and maturing into an adult body.

G. I want to talk to you about sex. You may already know about it, but I want to make sure that you feel comfortable talking to me. I will tell you about my (our) beliefs regarding sex and I want to know yours. Also, if you decide you are going to have sex I want you to tell me. There are some steps and protections that can be used to keep you safe from STIs and pregnancy. I am always here if you have any questions.
IX. Dating Safety Tips for Teens

Dating Safety Tips for Teens

A. Communication!!!!

- This is always number 1!
- Keep parents in the loop! It lets them know where to start looking for you if needed in a worst-case scenario. Also, if you need an out, your parents will know where to come pick you up at!
- If you feel like you cannot communicate with your parent in this way, have a trust adult that you can talk to or call.
- Update your social networking page when going out with friends or others. This provides a timeline and update of your location and activities.
- Bonus tip: Open and honest communication builds trust which often leads to more privileges!

B. Be aware of your surroundings!

- Know where you are and how to get home.
- Locate exits in any room you are in.
- Never separate from the group you arrive with. If you do, make sure they know where you are going.
- Bonus tip: Knowing how you arrive makes it easier to get back home if needed.

C. Be careful about foods and beverages!

- Never eat or drink anything that you didn’t see prepared.
- Never leave food or drink unattended.
- Never accept free drinks from anyone you don’t know and trust.
- Bonus tip: Awareness that food or drink has not been altered with drugs or alcohol.

D. Avoid alcohol and drugs.

- Judgment is compromised making it more difficult to stick to preset boundaries.
- Safety is compromised. There is a higher risk for nonconsensual sex.

E. Never meet someone that you have met online or through social media.

- It is very easy for predators to pretend to be someone they aren’t behind a screen.
- If this advice is ignored, make sure a meeting happens in a very public, well lit place with a lot of people around.
- Always know who you are meeting. Know their full name, phone number, what they look like, etc.

F. Consider group dates or dates in public places.

- This is especially true for first dates.
- There is always safety in numbers!
- Let at least one friend that isn’t in that group know where you are and who you are with in case of emergency.
G. Know your limits and stick to them.
   - Identify your boundaries or limits before you are in a situation.
   - Remember that you always have the right to say no or get out of any situation that makes you uncomfortable.
   - If someone is pressuring you into a situation that you don’t want to be in or if you feel threatened, get out as quickly as possible and contact a trusted adult.
   - Remember that you don’t owe anyone anything. You never have to do anything you don’t want to do!

H. What is consent?
   - Consent for sexual activity cannot be given by anyone while under the influence of drugs or alcohol. Yes means yes. No means no. There is no grey area.
   - Tea consent video: https://www.youtube.com/watch?v=fGoWLWS4-kU
   - The legal age for sexual consent in Alabama is 16. There is an age-gap provision of 2 years. Both parties must be over 12 years old to legally consent to sex.
   - It is ok to change your mind at any time.

I. Know who to call and their phone numbers in case of emergency.
   - Have an arrangement with a trusted adult that you can call if you need them. This may be a parent, aunt or uncle, teacher, or coach for example.
     - Make sure you know their phone number in case your cell phone is dead or missing.
X. Parent Tips for Supporting Safety with Teen Dating

A. Communication! Parents should always know where their child is and who they are with! Also, communicate after the date. Inquire how it went and what they did. Pay attention to verbal and nonverbal communication, specifically changes in body posture or facial expressions. Having an open and honest relationship with your teen will allow him/her to feel more comfortable talking with you when there is a problem.

B. Watch for signs of physical, psychological, or sexual abuse. Though it is easy to believe that abuse only happens in adult relationships, dating violence is more common than it should be. Be aware of behavioral changes such as becoming isolated, withdrawn, anxious, or having any other major personality changes.

C. Discuss personal and family values about sex. Parents can share their beliefs about sexual behavior with their teens and find out how their teen feels. Listening is vital. Though it can be hard to hear the teen’s point of view, listening may convey openness, understanding, and a non-judgmental attitude.

D. Discuss safe sex. Even if parents would choose for their teen not to have sex, the decision does not lie with them. Make sure that, if your teen does choose to have sex, he/she already knows how to do so safely. Topics that can be covered are birth control, scheduling of initial appointments with a gynecologist, types of STDs, and risks for pregnancy.

E. Parents should meet their teen’s date prior to an outing. Get to know the person that their teen is spending time with. It will give them peace of mind or allow them to intervene if necessary.

F. It is ok for parents to be a “convenient excuse” for their teen. They should make sure that their teen is aware that he/she can use them as a reason to say “no” or to leave a situation. Express willingness to pick their teen up anywhere, anytime, for any reason. If a teen is uncomfortable in a situation, having a way out will make it less likely that he/she will stay in it.

G. Instill self-confidence. It is important that a teen knows how much you value him as a person and that he values himself/herself as well. Believing in his self-worth will allow him/her to expect respect from those he/she surrounds himself/herself with.

H. Parents should teach their children about peer pressure. Talking about how to react or behave when being pressured by friends or dates can better prepare teens for situations when they occur. Also, parents should discuss with their kids the effects of pressuring or bullying other teens. Teach them how to look at things from another person’s point of view.

I. Teach your sons about how to receive consent and what that means. They need to learn about boundaries and not pressuring girls into unwanted situations. This is true for girls too. It is never ok for ANYONE to pressure another person into a sexual situation.
J. Try to be understanding and avoid judgement or scolding if your child approaches you with questions or disclosures. A teen may not feel comfortable talking again if they feel judged or “in trouble.”

(References: 17, 18, 19, 20, 21)
XI. Scenarios to Be Used by Therapists When Meeting with Parents

**Scenario 1:** Your child just came home after soccer practice and says my coach touched me in a way that I didn’t like.

*Ask Parents:* What are some questions you would ask?

How would you react?

**Scenario 2:** Your child is at a party and calls you and says, “I need you to come get me. I don’t like what is happening here and I don’t know how to get out of the situation.

*Ask Parents:* What do you think?

What do you want to do?

**Scenario 3:** Your child comes to you and states that he/she is thinking about having sex. He/she wants to know more about how to have safe sex.

*Ask Parents:* How do you respond?

How would this make you feel?

**Scenario 4:** Your child asks how babies are made and how they get out of the mommy’s belly.

*Ask Parents:* How do you respond?

How do you feel about this line of questioning?

What are your feelings about how much information should be shared at your child’s specific age group?
XII. References


XIII. Diagrams
Appendix F

Research and Creative Experiences for Undergraduates (RCEU) poster presentation at The University of Alabama in Huntsville in August 2018.

Supportive Resources for Teaching Healthy Sexuality and Body Maturation During Trauma-Focused Cognitive Behavioral Therapy

Jennifer Davis, Ann Bianchi, PhD, RN
College of Nursing

Overview/Introduction
Child sexual abuse (CSA) affects a multitude of children in our society. During the disclosure process and throughout therapy these children will come into contact with professionals from a multitude of disciplines. It is important for professionals working with CSA victims to have a working knowledge related to all disciplines. This is especially true for therapists who have the longest lasting relationship with the child and will encounter many different scenarios and questions throughout therapy.

Purpose
The purpose of this study is to evaluate the effectiveness of supportive resources provided to counselors at the National Children's Advocacy Center (NCAC) when teaching healthy sexuality, body maturation, and body safety during trauma-focused cognitive behavioral therapy with children and parents.

Methodology
- A focus group with therapists from the National Children's Advocacy Center (NCAC) to identify needed resources to use during TF-CBT
- In response to requests from the therapists, 12 educational supportive resources were created relating to healthy sexuality and body maturation to enhance their knowledge and comfort level with the given topics.
- Corroboration testing was used and 9 therapists from NCAC and NOVA agreed to participate. The participants were asked to fill out a demographic form and the Pre-Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire.
- The 12 educational supportive resources were provided to the therapists to use for a period of approximately 3 months.
- At the end of the 3 month period each participant will complete the Post-Assessment Questionnaire.

Data Analysis Plan
When all participants have completed the Post-Assessment Questionnaire data analysis will begin Fall 2018. Descriptive statistics will be used for demographic data. Paired t-test will be used to analyze the Assessment of Knowledge and Comfort Level When Discussing Healthy Sexuality, Body Maturation, and Body Safety during TF-CBT Questionnaire scores to the post-assessment scores.

Implications to Nursing Practice
Nursing has long been a profession of education. Nurses educate each other, the community, and their patients. This study will show that there is a benefit for the education of other disciplines by the nursing community and for an increase in collaborative care between therapists and nurses. In any discipline the increase in knowledge pertaining to other disciplines they interact with will do nothing but benefit patient care.

Review of Literature
- There is a need for education among therapists regarding sexual health issues.
- There is also a lack of compliance in relation to medical follow up after CSA disclosure that is in contrast to the high percentage of patients who had their child follow up with therapists.
- A 1990 evaluation of interdisciplinary training found that the education led to an increased knowledge of physical indications of sexual abuse in non-medical staff.
- No research was found that focuses on the cross-education of therapists in this area by the nursing community in relation to new best improve knowledge levels for the benefit of CSA victims.

References
Appendix G

2018 University of Alabama System Honors Research Conference Participation Form

This submission form is for University of Alabama System Honors College students who would like to participate in the 18th UASHRC on Friday, November 2, 2018.

Email address *

jld0031@uah.edu

Presenter's First Name *

Jennifer

Presenter's Last Name *

Davis

Presenter's University of Alabama System E-mail Address *

jld0031@uah.edu

Presenter's Phone Number *

2566143268

Honors Student in Good Standing at: *

• ( ) University of Alabama in Tuscaloosa
• ( ) University of Alabama in Birmingham
• (X) University of Alabama in Huntsville

Your Major(s) *
Nursing

College(s) in Which Your Major(s) is/are Housed (ex: College of Business Administration, etc.) *

NUR

Title (Dr., Mr., Ms., etc.) and First and Last Name of Mentor/Advisor/Project Director *

Dr. Ann Bianchi

Department and College of Mentor/Advisor/Project Director (ex: Department of Physics, College of Science) *

NUR

E-mail Contact for Mentor/Advisor/Project Director *

ann.bianchi@uah.edu

Phone Number of Mentor/Advisor/Project Director *

256-824-2465

Type of Presentation *

- (X) Podium Presentation (10 mins including brief Q&A)
- ( ) Poster Presentation

Title of Presentation

Supportive Resources for Teaching Healthy Sexuality and Body Maturation During Trauma-Focused Cognitive Behavioral Therapy

Abstract/Description *
The purpose of this study is to evaluate the effectiveness of supportive resources provided to counselors at the National Children’s Advocacy Center (NCAC) when teaching healthy sexuality, body maturation, and body safety during trauma-focused cognitive behavioral therapy with children and parents. Resources were created and distributed to therapists at the NCAC and NOVA. The therapists filled out a pre-assessment survey regarding knowledge and comfort level while teaching healthy sexuality and body maturation and then used the resources for a period of approximately 10 weeks. After the 10 weeks the therapists filled out a post-assessment survey. The results were analyzed with paired t-tests.

Meal Preference *

- (X) Regular
- ( ) Vegetarian

Any Additional Information
Dear Jennifer,

On behalf of the National Children's Advocacy Center, thank you for agreeing to present during the 35th International Symposium on Child Abuse, March 18-21, 2019. Your workshop submission has been approved.

By serving as a Symposium presenter, you will receive complimentary Symposium registration. (Co-presenters will receive a 50% reduced registration fee.) Registration provides access to all Symposium workshops and activities, which include daily continental breakfasts and lunches, refreshment breaks, and evening events.

Symposium will begin at 8:30 am on Tuesday, March 19, 2019, with an Opening Plenary Session and will conclude at 4:30 pm, Thursday, March 21, 2019. Monday, March 18, 2019, is an optional pre-conference workshop day. Should you wish to participate, select your preferred pre-conference workshop during registration. There is a $99 fee.