THE HUMAN SEXUALITY INFORMATION AND COUNSELING SERVICE: A UNIQUE AND QUALITY ALTERNATIVE

ROBERT A. DIAMANT, EDITOR

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A Unique and Quality Alternative

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FOREWORD

This paper has been written in the belief that we can all be resources to each other. As human resources, we can give many things to each other that will make all of our lives healthier and more pleasureable. The Human Sexuality Information and Counseling Service is a group of people who are trying to help people to have fuller lives by giving to others the information, the resource referrals, the counseling and/or the opportunity to talk about their sexuality, and consequently to increase their awareness, understanding and acceptance of their whole selves.

We have not written a guidebook for peer health education services. This is a description and history of our Service, the growth and changes that we have gone and are still going through. Hopefully it will be informative and useful.

We are interested in your response to this report and to our Service. We are also very interested in any work that you are doing in the area of health education and sexuality. We invite any questions, concerns, ideas or other comments that you have. We would like to correspond with you. All of the authors cited in this report may be contacted in care of our office.

Robert A Diamant

Robert A. Diamant, Director, 1973-74

Jerry Noble

Jerry Noble, Director, 1974 -

INTRODUCTION

The purpose of this report is to provide a description and historic overview of the Human Sexuality Information and Counseling Service (HSICS) at the University of North Carolina at Chapel Hill as a model for any individual, group of people, agency, or institution, that is interested in developing, continuing, improving or studying a peer-staffed health education service. This report is written in the belief that peer counselors and educators make available information and services to certain segments of the population (those that choose to use them) that can only be provided by peers. The reasons for this seem to be a lack of awareness, availability, accessibility or desirability of other services. A good peer-operated health education service is not an inferior substitute for professionals but a unique and quality alternative.

This report is a combination of the observations and writings of several people. Those papers which have been excerpted are marked with the author's name at the beginning of the section. All editorial deletions, additions, and changes have been made by me, Robert Diamant (Director 1973-74), with the awareness and permission of the respective authors. All unidentified writing is my own. This report documents our development from September, 1971 through April, 1974.

WHO WE ARE AND WHAT WE DO

The HSICS is an all volunteer staff (I am the exception, having received federal work-study compensation during the past year) of forty-seven men and women, three-fourths of whom are students at the University of North Carolina at Chapel Hill. Our counselors/educators represent a wide variety of academic and professional disciplines and range in age from 19 to 37 with the mean age in the early 20's. Since our inception in October, 1971, we have had individual contacts (by telephone or in person) with over 4,500 people, have communicated in groups with over 2,000 people, and have distributed over 20,000 pamphlets, booklets, information sheets, etc. We serve the University and the surrounding community.

Our office is open (usually staffed by male and female pairs) six days a week (11-5 and 7:30-9:30 Monday through Thursday, 11-3 Friday and 12-3 Saturday). We maintain shorter hours during the summer. People contact

us either by telephone, in person or by written correspondence. A "code-a-phone" gives a recorded message to telephone callers when we are closed; the message states that we are closed, our regular hours, and the names and phone numbers of several counselors who can be called in case of an emergency.

We were created and operate with these three primary objectives:

1. to provide accurate and up-to-date information on the different aspects of sexuality;
2. to refer students and other people to the services offered by the University and non-University community dealing with sexuality; and
3. to talk, on a one-to-one basis, with people having concerns within the realm of sexuality and interpersonal relations.

Another objective might be added:

4. to achieve these first three goals in a group situation whenever this is desireable and preferable.

We attempt to accomplish our goals through a selective screening program, a comprehensive and on-going training program (that emphasizes: an awareness and sensitivity to the feelings, thoughts, and experiences of self and others; an informational knowledge of the biological/medical/psychological aspects of sexuality; and an experiential, practical, and theoretical understanding of basic counseling skills), and continuous contact with and awareness of changes and developments in research and referral resources in sexuality.

Within our service are specially trained male and female pregnancy counselors, bisexual and homosexual resource counselors and educational outreach facilitators. Our staff uses many professionals as personal and referral resources. We are also in frequent communication with our faculty consultant, a psychologist with UNC's Student Health Service.

We are funded by a small grant from the UNC student government (Campus Governing Council). The service occupies (rent free) an adjoining pair of rooms within the Student Union, one for counseling and the other for administration (during our first half year of operation, our offices consisted of a corner of the busy student government's lobby)! We have two telephone lines, one for counseling (with the code-a-phone) and one for the administrative office.

The HSICS is an evolving and expanding organization of creative, dedicated people. We are continuously becoming more effective and innovative in responding to the sex-related concerns of people in our community. As our confidence and credibility grow, we are increasingly taking the role of consumer advocates and catalysts of change. The process is, and always has been, difficult, but over-riding the frustrations has been the firm belief that people should and will have the knowledge and services that will allow them to understand and feel good about themselves as sexual beings.

HUMAN SEXUALITY INFORMATION AND COUNSELING SERVICE

AN EVALUATION AND CRITICISM OF THE FIRST YEAR OF OPERATION

Robert R. Wilson, Director 1971,Spring - 1973

(Some parts of Robert Wilson's original evaluation and criticism have been omitted because the material was no longer valid or else did not meet the objectives of this larger report. Most items that have been deleted are updated and included in other parts of this report. This paper is included in order to give context to our later transitions. Robert Diamant)

LAYING THE GROUNDWORK

The members of the Human Sexuality Committee were justifiably disappointed in the educational resources available to students on campus about the different aspects of their human sexuality, when the Fall, 1971 semester began at the University of North Carolina at Chapel Hill. It was felt that the students today, with their somewhat over-extended lifestyles, needed as many educational outlets as possible in this area, to help combat the sex education void of students prior to college life, to help assist them with questions and problems about their sexuality while they are in college, and to prepare them for their future life.

Attempts were made to supply a free sex education handbook to each entering freshman and junior transfer during orientation. No funds could be raised, so instead the book went on sale at the Student Stores for $1.00, an inadequate substitute.

Courses on campus concerning sexuality were less than five, reaching at most five percent of the students per year. The Committee helped administer one of these courses, "Topics in Human Sexuality", taught with 500 students per year. The waiting list for the course each semester, though, was twice the size of the possible enrollment.

The Student Health Service and its Mental Health Section on campus were willing to do their share in assisting the students with sexual problems, but their small budget prohibited them from providing complete and specialized service in this area.

In brainstorming about solutions to these problems, the idea of a student-run information and counseling service seemed to fit quite well. It could be designed and operated with three basic functions in mind:

1. to provide accurate and up-to-date information on the different aspects of sexuality;

2. to refer students to the services offered by the University community dealing with sexuality; and

3. to talk, on a one-to-one basis, with students having problems in the realm of sexuality and interpersonal relations.

Work began, in early September, on the Human Sexuality Information and Counseling Service.

The first step was to discuss the idea of such a service with some of those who would be involved: the students, the doctors and the administrators of the University. The response came with enthusiasm and with concrete suggestions. No negative response from anyone was received concerning the design of such a service.

THE TRAINING PROGRAM

Within two weeks from the start of the work I was ready to consider the training program for the "Human Sexuality Counselors". I met several times with Kay Goldstein, co-director of Switchboard Counseling Service, and Dr. William Eastman, marriage counselor for the Student Health Service. It was our belief that the basic information needed to begin peer counseling on sexuality could be presented in three sessions as long as the counselors understood their capabilities with such little training. We felt a training program to give student counselors more than just the basic information would take months of work and was completely unfeasable. Our concern was not that these counselors know the human physiology and anatomy in detail, but that they develop a sensitivity to the problems presented to them and to the needs of their counselees. The technical knowledge could come from professional resources when needed.

Once the training program was designed, I was ready to locate counselors and begin the training. A small three-line, three-day ad was placed in the "campus calendar" of the Daily Tar Heel, U.N.C.'s student newspaper, asking "anyone interested in being a volunteer counselor for a new sexual counseling team please sign-up in the student government office." Thirty-seven people signed up for training.

I sent each a letter explaining what the counseling service was designed for and when the training sessions would be. The letter informed them that of the thirty-seven only twenty would be chosen as counselors, based on their performance in role-playing exercises.

(Training program section of Robert Wilson's report is omitted, please see: "Human Sexuality Health Education and Counseling by Peers: Screening and Training", Baldwin & Diamant, pp. 13-18.)

TRAINING PROBLEM PREGNANCY COUNSELORS

In the month of January, (1972) ten of the Human Sexuality counselors began problem pregnancy counseling. Prior to this time, a person requesting abortion information was given the name of a counselor from the Women's Health and Pregnancy Counseling Group, an organization of trained female counselors operating through Switchboard Counseling Service.

The Human Sexuality Problem Pregnancy counselors began training in November under the direction of Ms. Kathie Gantt. The counselors met for training one night a week for two months.

During the first session, contraceptive methods were discussed in detail. It was also necessary to discuss where contraceptives and pregnancy tests were available for students and non-students within a 25-mile radius of the Chapel Hill area.

The various methods of abortion procedures were explained during the second session. There was also an exchange of feelings and opinions regarding abortions.

The third and fourth sessions were discussions of the different counseling procedures for the woman who: wants to get married and keep the child, wants to remain single and keep the child, wants to place the child for adoption, wants to have an abortion, or wants to commit suicide.

During the next three sessions the counselors practiced these counseling procedures by extensive role-playing. The counselors must know what questions to ask, what answers to have and what services are available for each alternative. They must also develop sensitivity and understanding for each situation.

The last session was spent discussing administrative details, making arrangements to write many of the Washington and New York abortion clinics for their information, and arranging for a counselor to visit each clinic.

During this two-month training period there were also two meetings with guest speakers. Mr. David Warren, associate professor of the UNC Institute of Government discussed many of the legal aspects related to each problem pregnancy alternative. Reverend James Riddle, Head of the North Carolina Clergy Consultation Service (CCS) discussed ways in which their counselors handle cases. He explained how the CCS could be a particular aid as a referral in that they specialize in handling minors.

The culmination of the training program was an all-day workshop of the Human Sexuality and Switchboard Problem Pregnancy Counselors. The morning hours were spent discussing such ideas as the qualities of a good counselor, the alternatives to a problem pregnancy, and the ways in which our services could complement and help each other.

Role-playing consumed the afternoon hours. The counselors were divided into groups of four. One counselor made up a hypothetical case. Another counselor acted as the "counselor". The other two counselors observed. A second series of role-playing took place in which different, very difficult cases were handled. The woman with the problem pregnancy was given a specific description -- hysterical, extremely inhibited, very defensive. After each role-play a discussion followed. The counselors were expressly asked to be constructively critical.

During and after the training program the 10 counselors were also busy designing their own "Problem Pregnancy Counseling Manual". Once completed, the manual contained the following information:

(Please note that this was written before the Supreme Court decision of 1973, allowing women free choice of abortion in every state. Therefore, the list of abortion resources is inadequate for today. See also Problem Pregnancy Counseling, Wiley pp. 32-34.)

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Guides to Abortion Counseling

Counseling Reminders
Counselor's check list
"About Abortion: Questions I should have answered better"

Abortion Procedures

Early termination procedures (up to 12 weeks) D & E, D & C
Late termination procedures (12-24 weeks) Saline induction, Hysterotomy
Experimental, Prostaglandins

North Carolina Abortion Information

Contraceptive Information
Pregnancy testing information
North Carolina Law with 18-year old amendment
Doctors East and West
Chapel Hill area information
Problem Pregnancy Counseling Information
Memorial Hospital
General information
Patient information

Washington D. C. Clinic Information

Preterm
Hillcrest
Prebirth
Washington Hospital Center

New York City/New York Area Clinic Information

Women's Medical Services
Park East Hospital
Eastgate Medical Group
2BBCC
Eastern Women's Center
University Place Center
Manhattan Women's Medical Clinic
Hillcrest Center
Pelham Medical Group
Monsey Medical Center
Dobbs Ferry Medical Pavilion

New York City/New York Area Hotels and Restaurants

Follow-up Information

Sample "feed-back" form - to be given to woman counseled
Counselor's sample follow-up form - to be completed by counselor

Additional Information

Problem Pregnancy and Abortion Counseling Project
Midwest Alliance Newsletters

ADMINISTRATION OF THE COUNSELING SERVICE

One strict rule was that every call and every "walk-in" case be recorded as completely as possible. A data sheet was completed for each case. The name of the counselee is recorded only if it is needed for referral and once the referral is completed the name is removed. The counselor is asked to record the problem or question of his or her case, then the advice given or the final outcome of the conversation. The detail of the report depends on the importance or uniqueness of the problem. A comprehensive file on all cases was kept by the staff coordinator, Emily Kenan.

The data sheets proved to be extremely valuable. The counselors were able to review every case handled the past week during their working shift. Incorrect information given can be spotted quite easily. Recurring cases by the same counselee can be more readily identified by different counselors. Certain patterns and overall effectiveness of the service can be obtained from analysis of all the data sheets.

Another great assistance was the Counseling Service Notebook, compiled to help the counselor answer factual questions quickly. The Notebook contained information on each of our major concerns, organized alphabetically. If the caller wanted to know, for example, how to obtain a venereal disease check-up in Wake County, the counselor would look up "V.D. -- Area Resources" for the nearest health clinic.

A separate folder was kept filled with copies of recent publications on sexuality, sexual problems, or counseling. Many of the counselors spent their shift reviewing these articles, keeping up-to-date with the work being done across the country in this area.

SPECIAL SERVICES PROVIDED

The Human Sexuality Information and Counseling Service was not designed to be self-sufficient while answering questions and counseling problems. One of our greatest assets was our complete referral service to more qualified individuals and agencies.

For students needing professional assistance, the Service provided up-to-date information on the services, fees, staff and hours of other facilities offering help in the area surrounding Chapel Hill.

The procedures for each facility was explained for such services as pregnancy tests, venereal disease tests and birth control assistance. An important function of our referral was convincing the student of the confidentiality of his or her medical record kept by any professional service. Students were most skeptical of the Mental Health Section of the Student Health Service, and this presented one of our most difficult problems. Many felt that their future employers would be able to find out that they had visited a psychologist or a psychiatrist. Students needing professional help sometimes refused to see anyone but our counselors. Not as many feared that their visits to a physician for a contraceptive method would be discovered without their permission.

Approximately 30% of our cases ended in the counselor suggesting referral to a professional agency. It is not known how many of these counselees followed through on the suggestion.

A referral system was also designed for general medical questions asked which were too difficult for the counselors to answer. Seven physicians, a psychiatrist, two psychologists and a marriage counselor from the Student Health Service, as well as a gynecologist from the U.N.C. School of Medicine, volunteered their services. A counselor could call on any one of these doctors during our office hours for assistance. Questions asked were ones most efficiently and quickly answered by a telephone and were not ones requiring diagnosis of a specific individual. Each doctor was sent a typed copy of the question and his or her answer so that any error in communication could be corrected as quickly as possible. The system worked exceedingly well, with over 75 cases referred in this manner.

As previously mentioned, during the first semester ten of our counselors were trained to be "Problem Pregnancy Counselors" for our Service. They were prepared to discuss the five alternatives open to a pregnant women: to be married and keep the child; to be single and keep the child; to place the child up for adoption; to have an abortion; or to commit suicide. Once our "Problem Pregnancy Counselors" were trained, all inquiries in this area were directed to them.

Our fourth special service was in the area of homosexuality. When the counselors met during our first training program, "Who handles cases about homosexuality?" was a difficult question. No one was quite sure. We concluded that we should handle it with the same sensitivity we use with other cases. Difficult problems in this area should be referred to professionals. This answer didn't quite satisfy us, but we knew of no other solution.

In December we were fortunate enough to have two homosexuals volunteer to join our staff as resource persons; both the male and female had counseled in this area before. In January four male homosexuals were trained as regular counselors. Our original two remained as counselors only in the area of homosexuality.

Any person coming to our Service with a homosexual decision, question, or problem had three options: he or she could talk with the counselor on duty, he or she could take with one of our homosexual counselors, or he or she could be referred to professional help. The counselor handling the case also had the option of receiving advice from the homosexual counselor without having the counselee talk with him or her.

HUMAN SEXUALITY HEALTH EDUCATION AND COUNSELING BY PEERS: SCREENING AND TRAINING MODELS*

Bruce A. Baldwin and Robert A. Diamant

INTRODUCTION

The screening and training programs for student staff have been increasingly recognized as the foundation of the Human Sexuality Information and Counseling Service. The student staff are the vital link between student and campus needs and the human sexuality health education goals of this service. Since students are the "medium of the message" in this service, designing screening and training programs for student staff that adequately meet service goals is imperative. Screening and training programs for new staff have presently evolved into a four-step sequence: 1) completion of application materials; 2) a personal interview; 3) competency-based screening utilizing simulation techniques; and 4) specific training in human sexuality information and counseling for screened applicants.

APPLICATIONS AND PERSONAL INTERVIEWS

When HSICS was first organized, screening and training programs for student volunteers were integrated in one sequence. There were few defined criteria for acceptable volunteers and emphasis was placed on gaining support for a new and controversial student program. As the service matured and gained acceptance, the HSICS staff became acutely aware that effective peer counselors are found and not manufactured through training programs. Although McCord and Packwood (1973) in their survey report that most peer services combine screening and training programs, HSICS has effectively separated the two with definite goals for each. Further, there has been subsequent division of the screening program into two distinct phases.

As the result of experience and experimentation with several screening models, a set of general characteristics of effective human sexuality counselors has been defined and now provides a general framework for screening. Students volunteering for service are evaluated on five general dimensions (Baldwin and Wilson, 1974b): 1) assessment of psycho-social adequacy and maturity of attitudes toward sexuality; 2) evidence that neurotic needs or conflicts are not the primary motivation in interpersonal or helping relationships; 3) demonstration of adequate interpersonal skills and the self-awareness to

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*Excerpted from article by that name, Crisis Intervention, 1974, in press.

further develop such skills; 4) commitment to the psycho-educational goals of the service; and 5) willingness to volunteer regular service hours and assume service responsibilities with few direct rewards. Individuals who will leave the area in less than one year or who are 30 years of age or older are discouraged from volunteering for service. These restrictions were instituted to insure continuity of service (i.e., reduce staff turnover) and to preserve the "peer counseling" emphasis of the service.

Implementation of the most recent service screening program for service volunteers was initiated early in the Fall semester 1973. Notice of the screening program for human sexuality peer counselors, with a deadline for completing applications, was placed in the campus newspaper and in two local papers. Local radio stations also carried spot announcements to the same effect. Additional efforts were made by HSICS staff to contact student leaders of minority groups on campus to recruit minority students for service.

The application form completed by students was developed to provide information to both HSICS and the applicant, and had several specific functions: 1) briefly define time commitments for the screening and training programs; 2) to outline expectations for service responsibilities if accepted as a new staff member; 3) to summarize information about the prospective trainee's background and personality; and 4) to aid in applicant self-assessment within the context of service goals and expectations. After listing basic biographic information, applicants responded to open-ended questions focused on previous relevant experience, personal strengths and weaknesses in relating to others, the meaning of sexuality, definition of personal sexual identity and motivation for applying for service at this time.

During the publicity period, approximately 150 applications were picked up by interested students. Of these, 55 were completed and returned to the service and made up the applicant pool for the screening program. Personal interviews were arranged for all students who completed the application form. Interviews were conducted by teams of two experienced HSICS staff members and all applications were read by at least three other staff members. The interview format consisted of an application review, direct interaction with the applicant, and a short period for processing information and note-taking. The application interview provided a basis for initial evaluation of applicant,

but simultaneously provided the applicant with a basis for evaluating the service.

To provide a guiding structure for evaluating applicants, a rating system was used by the staff evaluators. Each applicant was rated from 1 to 3 by both interviewers and the staff reading applications. These ratings reflected the evaluators' perceptions of that student's potential for additional screening and/or training. Each of the three ratings was defined in general terms as follows: Rating 1--interviewer/reader had significant doubts regarding counseling potential; Rating 2--interviewer/reader had minor reservations about specific aspects of applicant's potential but felt generally positive; Rating 3--interviewer/reader had essentially no reservations about applicant's capabilities. Each interviewer/reader attached a rating and notes justifying the rating to the application form for each student evaluated.

Pooled information for application materials, interviewer/reader ratings, and evaluation notes formed the basis for a decision about each applicant's suitability for inclusion in the second phase of the screening program. From the applicant pool of 55, the staff selected 28 students (7 men, 21 women) with the most positive evaluations for inclusion in competency-based screening. Those students accepted for additional screening were contacted by telephone and given details and all students selected elected to continue. Applicants not accepted for additional screening were sent a letter informing them of the decision and inviting them to contact the service for discussion of the decision if there were any questions. (None did, however.)

COMPETENCY-BASED SCREENING

The second phase of the screening program was designed to evaluate applicants in simulated helping contexts. All applicants participating were assumed to have excellent potential to become effective peer counselors. Direct observation of applicants empathic responses and interpersonal skills in role-playing situations has added a valuable dimension to the screening program. This final phase of screening enabled the service staff to have a final "look-see" at applicants under simulated counseling conditions.

Competency-based screening has become a crucial intermediate step between initial screening and acceptance into the service for training. This screening program is intended to constitute a separate learning experience

for all involved, including the HSICS training staff. However, it also complements the training program for which most participants will be selected. Optimally, the competency-based screening program will be a personal growth experience for all participants whether they are selected for additional training or not.

Competency-based screening was conducted on three consecutive evenings during late Fall 1973. Ten staff members from HSICS were involved as trainers for this screening program and were primarily responsible for its organization and design. Their task was to design a screening experience in which a non-threatening learning atmosphere was created and within which participants could function optimally in simulated helping relationships. In addition, the training staff met to define their roles in training, to discuss the interpersonal dimensions on which to observe participants, and to decide on a format for data gathering and decision-making for final acceptance of applicants into the service. The first evening of screening was devoted to developing group solidarity and a free learning atmosphere while the latter two evenings were focused on role-playing exercises.

On the first evening, participants were first given an overview of the screening program to set expectations. The five trainers present then divided the 28 participants into four groups of seven members each to begin an activity to draw the participants' attention to the qualities of an effective peer counselor. In these groups participants were asked to "brainstorm" to define the positive qualities of an effective peer counselor. These qualities were listed on newsprint and when lists had been completed each group was asked to decide which four of their listed characteristics were <u>most</u> important and to star them. This task led to discussion of how to effectively relate in helping relationships, definition and elaboration of terms and concepts, and (indirectly) helped group members become comfortable with one another. Each small group then selected a spokesperson to report to the large group their decision on the most important qualities of an effective peer counselor and why. These characteristics were integrated into a "master list" by trainers as each group reported. During group reports, discussion within the large group was generated and facilitated by trainers to further develop group openness. The evening ended with a generalized discussion of counseling and interpersonal relationships.

The next two evenings involved participants in simulated counseling situations which emphasized role-playing. The large group was broken into triads to role-play counselor, counselee and observer. On each evening, there were two role-playing "rounds" in which each participant played each of the three roles. During role-playing, ten HSICS staff trainers were present as observer/facilitators and were as non-directive as possible in relation to participants. During each of the role-playing rounds, each triad was observed by a different HSICS staff trainer.

In the triads, each "counselee" was given a 2-3 sentence problem statement or problem situation to focus the interaction. These statements reflected frequently encountered problems of students seeking help through the service (i.e., relationship problems, ambivalence about first intercourse, homosexuality, problem pregnancy). During role-playing, participants were not evaluated on their knowledge about sexuality, but rather their ability to deal with the person and the situation, their interpersonal skills, and their awareness of self and others in the interactions. After each one-hour role-playing round, each member of the triad evaluated the experience. Staff trainers did not offer comments, but served primarily to facilitate and structure the exercise in a low-keyed manner. However, feedback and comments were given when necessary for the comfort of participants.

Staff trainers took notes as they observed each member of the triad in each of the three defined roles. Following the first evening of role-playing, the training staff met to share observations, discuss specific strengths and weaknesses of participants, and to resolve minor organizational problems of the screening program. On the last evening of role-playing, staff trainers met to share further information about participants and to make decisions on acceptance of participants into the service. During this meeting, favorable decisions were made on 26 of the 28 participants in the screening program. One male and one female were not accepted because of interpersonal difficulties. The male was a homosexual who was not accepted because of pervasive evidence of confusion about self and identity which significantly impeded his ability to respond to and help others. The female was not accepted because she was felt to be too hostile and resentful to be effective in helping relationships.

Following staff decisions, participants were notified of acceptance by telephone and all accepted the invitation to become HSICS staff members. The two rejected applicants were notified of the staff decision personally by individuals who knew them. Decisions were considered final and were reported to the HSICS staff at the next meeting by trainers.

THE TRAINING PROGRAM

The training program for new staff needed the breadth to prepare them for a variety of services to students and the campus community. Although initially involving only "relationship" training and information dissemination, the training has differentiated considerably since HSICS began. The present training program encompassed both personal development of staff as well as service skills and responsibilities.

More specifically, present training provides learning experiences along five major dimensions: 1) information about various aspects of human sexuality and sexual expression; 2) awareness of self, sexual identity and personal style of communicating; 3) specific interpersonal/counseling skills needed to effectively relate to others; 4) organization, activities and administration of the service; and 5) service goals and responsibilities to the students at the University of North Carolina.

As with screening, HSICS staff trainers were instrumental in both designing and implementing the training program. Trainers met several times to define and organize the training, to build their skills as trainers/ facilitators, and to discuss specific training problems and ways to handle them. In addition, several HSICS staff members were more directly involved as presenters for various informational aspects of the training program.

The training program provided new counselors with about 30 hours of training in addition to the approximately eight hours spent in competency-based screening. Training was carried out as a part of two general staff meetings, on several evenings, and during two weekend periods. General staff meetings which included training served to increase the knowledge of all staff members, but also gave new staff members experience in the conduct of meetings and an opportunity to participate and feel "part of" the service. The training program in brief descriptive form is presented below.

December 6 -- Full Service Training Meeting I.

Introduction Activity: Seated in a circle, new and experienced staff members introduced themselves and commented on their reasons for present involvement in the service.

"Rapping": During a short period of unstructured time with refreshments, new and experienced staff were able to mix and become better acquainted.

Student Health Service: Two physicians, a man and a woman, presented the Student Health Service, its policies and its problems, as well as how the HSICS staff can most effectively relate to them and to the other professional staff members. The physicians responded to questions from the HSICS staff.

January 10 -- Full Service Meeting II.

Human Sexual Inadequacies: A physician trained by Masters and Johnson presented definitions, descriptions and dynamics of specific types of sexual dysfunctions commonly experienced by young adults. Included were comments on obtaining an adequate sexual history and ways to increase client comfort when discussing sex-related issues or problems. A question/answer period followed the presentation.

January 12 -- Sex/Love Autobiography: Each participant wrote a sex/love autobiography that they would be willing to share with others. In small groups, material from these autobiographies was discussed and helped participants accept their own sexuality and to understand and accept diversity of sexual experience in others. This activity was facilitated by the HSICS Director.

Integrating Counseling Techniques: In small groups, participants role-played to practice various counseling techniques, including questioning, advice giving, non-directive approaches, and self-disclosure. The consequences of excessive use of single techniques were demonstrated and discussion emphasized integration of techniques into a personal counseling style. A counselor from the Student Health Service presented this activity.

Contraceptive Information: A short film presenting an overview of both effective and ineffective methods of contraception was shown. Following the film, additional information on the anatomical, physiological, and medical aspects of various types of contraception was presented by a HSICS staff member who was a graduate student in public health education. A discussion period followed.

January 13 -- Co-Counseling Exercise: Participants were paired and were alternately counselor and client with their partner. Observers periodically presented interpersonal observations and feedback to partners. The activity stressed awareness of interactional dynamics, experiencing the client role, and developing counseling skills. The discussion that followed centered on various client expectations for helping relationships. The activity was led by the HSICS student Director.

Homosexuality and Mental Health: This presentation by a Student Health Service psychologist defined the special psycho-social problems of the homosexual, outlined the changing mental health views of homosexuality and distinguished between homosexuality and pseudo-homosexuality in young adults. Dealing with the homosexual as a person was stressed.

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The Homosexual Subculture: HSICS staff members who were also homosexual resource persons discussed their experiences in understanding and accepting their sexual orientation. Other information on the gay subculture, homosexual lifestyles, and the process of helping another "come out" was presented with a question/answer period following.

January 15 -- Problem Pregnancy and Abortion: A physician from the community presented problem pregnancy as a crisis for the young adult woman, pregnancy testing procedures, various methods of abortion, and uses of menstrual extraction. Medical implications of these procedures were outlined and the presentation was followed by a question/answer period.

January 17 -- The Peer Counselor as a Helper: This group exercise helped participants to define similarities and differences among professionals, peer counselors and friends in helping relationships. The HSICS student Director led this activity which focused on helping new staff to solidify an identity as a peer counselor and to recognize their limitations in effectively helping others.

Types of Questions: In small groups, participants conceptualized different kinds of questions, including open and closed questions, direct questions and inquiry statements. The activity provided an opportunity to practice verbalizing various types of questions and was led by the HSICS student director.

Venereal Disease: A former VD counselor presented types of venereal disease, recognition of symptoms, and appropriate medical treatment for each type. Local facilities for treatment of venereal disease, policies on confidentiality, and follow-up procedures for individuals who had sexual contact with someone with venereal disease were discussed.

January 19 -- HSICS Outreach Programs: Service outreach programs were presented by the HSICS outreach coordinators. New staff members were helped to understand the nature and scope of outreach educational programs to community organizations, university classes, residence hall groups, and other helping agencies. The special problems of outreach programming, as well as future directions, were discussed.

Problem Pregnancy Counseling: The HSICS Problem Pregnancy Coordinator defined procedures for referring women with actual or potential problem pregnancies to the problem pregnancy counselors. Included was an overview of the problem pregnancy counseling program, special problems in dealing with problem pregnancies, and establishing rapport with women experiencing such problems prior to referral to the problem pregnancy counselors. Alternative counseling to deal with problem pregnancy choice crises was discussed.

Special Projects: The HSICS Special Projects Coordinator discussed past projects as well as projects presently being explored. A past statewide workshop of problem pregnancy counseling, a television series on human sexuality now being explored and plans for short symposia on various aspects of human sexuality for students were overviewed.

Service Policies and Procedures: The HSICS student Director discussed the service organization, its historical development, administrative procedures, and staff responsibilities. A question/answer period followed the presentation.

Outpatient Mental Health Resources: A psychologist from the Student Health Service discussed university and community outpatient mental health facilities to which HSICS staff can refer students. Included were referral procedures, contact persons in each clinic and general organization of these clinics. A group therapies program originating in the medical school was also presented as a referral resource. Specific written materials pertaining to peer counseling and telephone counseling were presented to the staff as educational resources.

These presentations completed the training for new HSICS staff members, but this training was considered to be only the "basic" training needed for effective peer counseling in human sexuality. To supplement the training presentations, new staff were asked to read specific resource materials* on human sexuality concurrently with the training program.

Following the training program, new staff members became "interns" for a two-week period. Each new counselor was assigned to one three-hour service period each week for two weeks with an experienced HSICS staff member. During this time, new staff did not counsel but became acquainted with the physical facilities of the service, discussed procedural/administrative questions with the experienced staff member, listened as the staff member responded to calls from students, and reviewed write-ups of previous HSICS counseling contacts with students. The internship period provided a transitional "breaking'in" period after which new staff members were teamed with experienced staff members to assume regular service hours and responsibilities.

Participants completed an evaluation instrument to assess the effectiveness of the training program. The instrument consisted of 45 items describing the various activities and presentations during the training. New staff members rated each item on a 6-point scale from negative (rating 1) to positive (rating 3). Several open-ended questions were included to elicit other reactions to the training as well as specific suggestions on how to improve future training programs. Reactions of new staff were consistently positive, although some aspects of training were rated more positively than others. Several specific suggestions for improving training will be incorporated into future training and screening programs.

For examples of screening and training materials see Appendix II.

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* Resource materials read were: <u>Understanding Human Sexual Inadequacy</u> (Belliveau and Richter, Bantam Books, 1970); <u>VD Handbook</u> and <u>Birth Control Handbook</u> (Cherniak and Feingold, Montreal Health Press, 1973); and <u>Our Bodies, Ourselves</u> (New England Free Press, 1973).

A CAMPUS PEER COUNSELING PROGRAM IN HUMAN SEXUALITY*

Bruce A. Baldwin and Robert R. Wilson

Alternative services fill gaps between need and service and are often organized in those areas where the "generation gap" between youth and adults (and professionals by implication!) is greatest. Student-adult attitudinal differences may result in ambivalence toward and distrust in professionals and the institutions they represent in service areas where perceived differences exist. Such consumer ambivalence appears to be particularly operational when services are needed in the area of human sexuality. As a consequence, alternative services become more attractive because of this characteristic distrust and other qualities perceived to be inherent in peer services (Baldwin, Liptzin, Goldstein). Attributes of peer services attractive to youth include: 1) services that are rendered in an informal manner; 2) services that are available immedately upon request with little imposed structure (i.e., "appointments," etc.); 3) help that is present-oriented and practical; 4) anonymity can be preserved and there is little data gathering/record keeping; 5) helping relationships are perceived as more egalitarian; 6) there is more felt acceptance of behaviors and life styles (i.e., not deemed pathological); and 7) services provided usually are free.

PEER VERSUS NON-PROFESSIONAL

Vic Schoenbach

The notion of peer counseling seems to have arisen for two reasons. First, professionals and to a great extent "over-thirty adults" in general disqualified themselves as reliable and sensitive counselors on issues such as drugs and sex. They disqualified themselves partly through their ignorance on these subjects but primarily through their unwillingness to offer information and sensitive listening uncontaminated by moralisms and personal, even institutional and legal, censure. Such behavior by many adult professionals widened the breach of distrust between the generations and created a need for counselors who would deal with socially sensitive problems in a non-moralistic, accepting way.

The second reason for the rise of peer counseling relates to the advantages of "peers" in themselves. By minimizing the social distance between

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*Excerpted from article by that name, <u>Journal of the American College Health Association</u>, 1974, in press.

client and counselor, more fruitful interaction often results. First, the young person in difficulty may hesitate longer before seeking professional assistance than he or she would before going to a peer counselor. Second, once in contact, the equal social status facilitates conversation and exchange of feelings. Not being a professional having to ration his or her time, the peer counselor can operate with a high degree of informality and such relaxed circumstances are apparent to the client as well. Furthermore, talking with a peer counselor involves a lesser acceptance of the "sick" role than seeing a professional.

Other advantages of peer counseling involve the non-routinization of part-time counseling and the low financial outlay.

Over the last five years, the situation which gave rise to peer counseling has changed in a number of respects. In our own situation, the Student Health Service has considerably improved its responsiveness to student needs regarding sexual problems. Problem Pregnancy Counseling, for example, is now available with no fear of disciplinary action or censure. Contraceptive counseling is similarly available. Moreover, expanded publicity about these services is reducing the barrier to their utilization.

Similarly, though there is a long way to go; professional training is slowly beginning to include more in the sexual area and increasing numbers of professionals are attending workshops and short-courses providing information and attitude reassessment. Attitudes among the "over-thirties" have become more accepting and those who were accepting all along are less afraid to make their views known. While the situation has not been reached yet, we can expect that before too long the first set of reasons for the rise of peer counseling will diminish, at least regarding sexual problems.

The second set of reasons, though, will probably remain valid for some time to come. The experience of consulting a peer counselor is not necessarily an exclusive alternative to consulting a professional. Rather, the two alternatives are complementary. Professionals can offer certain things and peers can offer others. Furthermore, peer counseling requires minimum funding and offers volunteers the opportunity to do a valuable and fulfilling service. Accordingly, we can expect a continuing role for peer counselors in whatever subject areas the client population experiences the need.

SEX EDUCATION OUTREACH PROGRAM*

Dusty Staub

INTRODUCTION

To illustrate the present health problems, consider the situation at the University of North Carolina at Chapel Hill. It is composed of a population generally well-educated, progressive and modern. The campus has a Student Health Service where contraceptive counseling and prescriptions are available upon request. Also available are a plethora of various counseling services, one of which is HSICS, a peer model. Despite these resources and a generally advantageous situation, personal health problems appear in abundance. In the spring of 1972, the Director of HSICS, completed a survey which revealed that nearly three-fourths of the undergraduate population had engaged in sexual intercourse at least once. Yet, a majority had not employed effective contraception (Robert Wilson, 1972). There have been over 560 problem pregnancy counseling cases since the inception of the service, as well as an increasing volume of requests for health education programs. What is necessary is an improvement in general health education in order to help prevent these and other sexual concerns from developing into problems.

The service philosophy which has contributed to the development of a program specifically for Outreach can be summarized as follows:

a) to promote the acceptance of sexuality as a healthy and natural component of human experience

b) to know the extent and limitation of peer expertise and knowledge and thus develop good referral skills

c) to be aware of one's personal biases and feelings in certains areas of sexuality

d) to be non-judgmental and stress acceptance

e) to provide accurate and up-to-date information through a continuous health education effort

f) to be aware of and help construct as many resources as possible to meet the education and health care needs of the community

g) to encourage students to assume responsibility and control for their own sexual behavior

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* (The Sex Education Outreach Program has had a secondary role within HSICS until this past year. This paper was written in the Spring of 1974)

h) to promote group cohesiveness and to provide opportunities for exploration of personal feelings and mutual self-growth

i) to show concern and compassion for each other and our fellow human beings

j) to open dialogue between individuals and groups

k) to enlarge the attitudes of professionals and educators on the issues of human sexuality

l) to be eclectic in the approach to counseling and health education efforts

Most of the work in the first two years centered around the office and telephone service. The Health Educational Outreach activity, an active attempt to go out into the community, had been a part of the service since its inception, though never organized into a specific program (Baldwin, Wilson, 1973). Because of this lack of organization, requests for outreach services were often not communicated to interested counselors. Also there was the need for more preparation in developing skills for outreach programs. There was an inability to fulfill the goal of helping increase the community's understanding and knowledge of individual sexuality. The increasing volume of requests threatened to overwhelm the outreach efforts and a structure was needed to answer these requests and to develop specific programs for the requests. Needed was a procedure for noting a request, communicating it to the appropriate people, re-contacting the party making the request, organizing the program, and writing a report on its outcome.

Thus, the outreach program was organized to meet a) the increased requests for community education programs, b) to provide an organized and trained education force, c) to coordinate the efforts of individual counselors, d) to deal systematically with incoming requests for programs as well as developing the programs themselves, and e) to facilitate communication both among counselors and between the service and the community.

REQUESTS: WHERE THEY COME FROM

Program requests from August of 1972 to July of 1973 came from residence members in five dormitories, some university instructors, as well as a few local community centers such as a high school, a church and a few fraternities and sororities. A total of eighteen programs were delivered and they reached 435 men and women. Most of these programs were requested by dorm staff or residents, individual members of a fraternity or sorority or an instructor in a university course. Some requests were generated by HSICS counselors by

talking with friends and advertising the fact that this educational service was available.

The nature and origin of the requests began to change during the Fall of 1973 along with the development of the Outreach structure. Public schools began to request programs (six classes at Chapel Hill High School) as did the school of nursing, a half-way house for youthful offenders in Durham, residence directors in the dormitories, and the Health Education 33 classes (seminars in human sexuality). The nature of the programs changed when the service did programs for residence hall staff and nursing students, since the main thrust was to provide training in counseling skills, and not just to provide informational education. Increasingly, programs came to include practice sessions for other resource groups in the management of sexual topics in counseling and interpersonal concerns. Utilized in these training programs were modeling behaviors and role-playing models previously developed with Dr. Bruce Baldwin of the Student Health Service and learned during previous screening and training periods by service counselors.

This evolving trend in request origins continued into the Spring of 1974. Presentations included six classes at Orange High School, one class at Jordan High School (both in different cities), a continuing series of programs at Troy House, the half-way house for youthful offenders, two to Raleigh teenagers at a downtown teen center, a two-part program for a graduate class in clinical psychology and a two-part program for the first-year medical students, one for the second year medical class, a class of nurse practitioners and a local elemtary school for which we developed a four-part series. Many of these requests came from students or teachers who identified a vital need for something more than what was available through regular channels. Sexual behavior labeled as problems, misinformation, trends towards rising pregnancy rates and an increase in relationship problems as well as a lack of adequate education in topics in human sexuality were cited by those requesting programs as the reasons prompting the requests.

Thus far this year, September 11 to April 16, 1974, Outreach has delivered 57 programs and reached 1,298 people with a total of 600 person hours.

THE COORDINATING STRUCTURE

The organization of the program was undertaken by two HSICS counselors, Robert E. Staub and Carl W. Mengel. They became the coordinators with Vic Schoenbach, M.P.H., as special consultant. The first task for the coordinators was to develop an Outreach request sheet and a specific format for responding to requests. It was decided that responsibility for programs would be alternated and that the following procedures would be followed:

1) a specific request sheet would be used listing the name of the caller, date of the call, phone number, place and date proposed, topics of interest and if they wished to see a questionnaire of available topics.

2) the sheets were to be posted on the bulletin board and checked in the morning and afternoon by the coordinators.

3) the coordinator responsible for a request would call the person generating the request and clarify the time and date, topic areas and needs of the group

4) the coordinator then called counselors who had expertise or interest in the topic area and assisted them in developing and/or leading the program

5) if possible a questionnaire or follow-up evaluation was used to obtain feedback on the presentation

6) written evaluations and data sheets were to be taken and kept for future reference

Resource lists were updated and new ones written. The coordinators viewed films available through the University and critiqued them. They listed visual aides, booklets and collected contraceptive supplies for presentations. A letter was written with a list of the topic areas for presentations and it was sent to the residence hall staffs and to a few other community members. The expanded service was also advertised in the campus newspaper.

Af first, the coordinators responded to requests by personally leading or co-leading programs with experienced and inexperienced counselors. Seventeen of the twenty programs in the first semester had either or both coordinators as leaders. Feedback was obtained by follow-up contacts and from counselors who had been observers in the audience. Thus there developed a feel for what strengths and weeknesses were in the programs and common problems were identified and worked out. Reading the data sheets and having the feedback from

observers increased and refined the skills. The information kept on data sheets included: place, size of group, date, time, those presenting the program, observers, length of program, topics covered and process notes (format, response of group, questions asked, and a summary of the session). Near the end of the semester it was decided that the up-coming screening program for new counselors should heavily emphasize and reflect the need for health educators. The training program for new counselors was also considered a vital part of the Outreach effort. Much of the knowledge and skills needed by the Outreach personnel came from the general service training, small group experiences, role playing, the sharing of threatening and sensitive feelings, the training by professionals, the lists of referral resources and the intensive readings and presentations by regular HSICS staff members. An apprenticeship period was also devised during which new educators would attend several programs as observers and participant observers under experienced health educators with Outreach.

PRESENT AND FUTURE DIRECTIONS

The Outreach Health Education effort has directed itself to the needs of the surrounding community. Birth control and venereal disease booklets have been distributed at the dormitories and at every Outreach program. Personnel have developed and expanded their skills as health educators. In addition to the apprenticeships and original service training, a program in small group facilitation was presented March 21, 1974 to fifteen HSICS counselors. This particular program was designed by the Outreach Coordinator, the HSICS Director and members of an education class in group processes. It stressed learning through an experiential and discussion process.

The impetus presently is towards developing further on-going programs of a two or more visit series. Two of the clearest and most effective Outreach models are the Ephesus Church Elementary School program and the program delivered to a class of first year medical students.

Outreach personnel, working in teams, are delivering programs on an average of two a week. The programs are reaching more people this semester and utilizing more counselors than ever before.

There are plans for an even greater educational effort this summer and next fall. The Ortho film "Sexuality and Communication," will be shown this summer to the campus with the service providing facilitators for discussion

groups afterwards. The film and facilitation program, if well received, will be delivered again in the fall for the campus as a whole. Outreach counselors are planning to utilize the models developed this year to increase sex education on the elementary and high school levels. Models of programs will be provided to interested groups and seminars and workshops for area teachers are being considered. The programs for the medical and nursing schools may also be repeated. Residence Life has notified the service that the Residence Directors will be making greater use of Outreach in their staff training. Counselors will be working with Assistant Dean Albo Smith of Student Affairs in preparation for a week-long seminar on sexuality for next fall's freshman class. Outreach will lead a two-hour session for local teachers on how to teach sex education as part of a one-day workshop sponsored by the local chapter of the National Organization of Women and Lollipop Power. Counselors are also working on special projects. These include an effort to secure broadcast of a televised series on human sexuality over the University television network for the general public. Several counselors, some in the School of Public Health, are working on the formation of a women's health clinic.

DISADVANTAGES AND ADVANTAGES IN THE PEER EDUCATION MODEL

There are some disadvantages to the model: 1) lack of resources; little money for booklets, films or phone services, 2) the difficulty in getting training in group facilitation, 3) inexperience and lack of knowledge of potential conselors, 4) the opposition of health professionals who believe only they can do the job. This is mostly a matter of ignorance and misinformation on the part of professional medical and educational persons and the heritage of our "monopolistic viewpoint on knowledge", 5) time necessary for a program coordinator may mean that this has to be a paid position.

The advantages are numerous and outweigh the disadvantages.

1) It is possible to reach a large number of people with minimal resources because a) it is an immediate possibility in most communities

b) the cost is low

c) it is the best utilization of professionals as resources.

2) It expedites much of the work done in Public Health Departments and local agencies by educating the community and making appropriate referrals.

3) It increases community awareness and self-help.

4) It is pre-crisis intervention, breaking vicious cycles of ignorance and despair by reaching people before situations become critical or chronic.

5) It is the most effective and rewarding training experience for future health professionals.

For examples of two Outreach programs see Appendix IV and for a description of the training for Outreach personnel see Appendix III. Some techniques used by Outreach teams are described in Appendix V.

PROBLEM PREGNANCY COUNSELING

Minna Wiley

TRAINING

The Problem Pregnancy Counselors began the fall semester with five trained counselors. During the fall three more counselors, who had joined the HSICS during the summer, were trained. Participation is open to all regular counselors of HSICS, both male and female.

For the first training session, we spent an evening with Ms. Sharon Meginnis, a counselor with the Student Health Service, sharing facts and views on the abortion protocols at North Carolina Memorial Hospital, and on the legal status of abortion in North Carolina. This was also an opportunity to learn about Problem Pregnancy Counseling techniques. It was a mutually satisfying discussion, as Ms. Meginnis appreciated the opportunity to learn more about HSICS.

Our second session was on abortion procedures. Dr. Marysue Fulghum, a third-year resident in gynecology at NCMH, presented a very thorough and enlightening talk on all pregnancy termination procedures in use at NCMH, from menstrual extraction for very early pregnancies, to salines for pregnancy as late as twenty weeks. With this knowledge a Problem Pregnancy Counselor is well prepared to explain to a woman exactly what she will experience when she has an abortion.

We then spent several sessions learning about the philosophy of problem pregnancy counseling, the alternatives to an unwanted pregnancy, and various abortion and adoption facilities. The old counselors conducted this training. Before training began, we sent letters to many abortion clinics in Washington, New York, Georgia and North Carolina requesting literature on their facilities. As these arrived we distributed them to the old and new counselors. We also requested information from all major hospitals in North Carolina asking them to outline their abortion policies. The response from them was very poor.

Early in the semester we had a visit from a representative of the Women's Medical Center, which is a clinic we have frequently referred women to in Washington, D. C. Her presentation with slides helped the new counselors to have a better idea of what an abortion is like.

At a final session, we discussed administration, how to fill out confidential questionnaires, and generally tried to tie up loose ends. The new counselors were asked to read three books:

<u>Our Bodies, Ourselves</u>
<u>Problem Pregnancy Manual,</u> ed. Robert Wilson
<u>Abortion, the Agonizing Decision</u>, by David Mace

The new counselors started to take cases in January.

<u>SITUATIONS</u>

In Problem Pregnancy Counseling the counselor must help a woman reach a difficult decision in a short period of time. We never assume that a woman wants an abortion. We point out all of her alternatives and then are able to tell her where to go for further help with whatever solution she chooses. She is encouraged to confide in her partner or husband, and if a minor, in her parents. When a minor is reluctant to tell her parents we often refer her to a Clergy Consultation or to Ms. Frances Muith, who is a social worker at NCMH and who works with unwed mothers.

Many of our phone calls come from a boyfriend at the University of North Carolina whose pregnant partner attends some small college in the state. In these cases, the male often hopes to obtain information regarding abortion facilities which he will pass on to his girlfriend. We strongly urge the man to have his partner call the counselor and talk directly. This gives the woman an opportunity to air any feelings that she may have about the pregnancy and the counselor a chance to ascertain that abortion is her choice and she is not being coerced into a decision by her partner.

After general counseling about making the decision, the Problem Pregnancy Counselor must be prepared to share information about resources. In order to do so we must be continually learning about facilities and legalities. Though we are able to help a woman who chooses to have her baby and put it up for adoption, or keep it as an unwed mother, most of our requests are for abortions and therefore we have acquired extensive information on pregnancy termination facilities. Most of our counselors have visited at least one clinic where they have seen the entire setup, including witnessing an abortion procedure. They are thus able to tell a woman exactly what she will experience from the moment she walks in the door until she leaves.

All women who elect abortion are told about the possibilities in several states including North Carolina. With the facts we present, a woman can

decide for herself where to go and what choice is best for her.

Since the Supreme Court Decision of January, 1973, we have seen some advances in the availability of abortions, but not as much as one might hope for.

At this time, there are only two clinics in North Carolina. Of these we have not ever referred a women to the one located in Charlotte and will not do so until we learn that it has a back-up hospital for emergencies and until we have checked it out. The other clinic is located in Raleigh and has just opened this past March. Two counselors attended its open house and it appears to be an acceptable, if not over-priced facility. Before we start to refer women to the Raleigh clinic we would like to have one counselor visit it on a working day to see it in operation.

Our statistics show a great decrease in problem pregnancies. We cannot say at this time whether this is due to greater use of effective contraceptives or to the profit-making referral agencies which advertise extensively in local papers, or simply to the fact that since abortions have become legal and more readily available women are able to locate pregnancy termination facilities on their own. If this last situation is the case, one might speculate that since abortion has been removed from the underground realm, women are better able to make relaxed decisions about their problem, with a minimum of counseling. Even if this were true, there is still a great need for our service to continue to offer problem pregnancy counseling for there will always be women for whom this decision does not come so easily.

TRANSITIONS: ADMINISTRATION AND LEADERSHIP

Our staff has undergone many changes during the past two and a half years; one of the most critical of these has been the leadership. HSICS received most of its leadership energy and impetus from Robert Wilson, the first Director and the founder of the Service. Robert consistently gave thirty to sixty hours a week to the Service's operation during our first year and a half. In the early spring of 1973, Robert told the members that he would be leaving by the summer. As there was no precedent or policy to follow, the people most concerned about the administration and future of the Service began meeting regularly. It soon became clear that the responsibility of operating HSICS would have to be shared by several of us. Meeting with Robert, we divided the administrative responsibilities into several areas and decided to de-centralize these jobs, so that they would be done by several people instead of by one.

A Management Board formed during this period which served the function of making and carrying through the essential (but tedious to those who were uninterested) operational decisions that had either been made by the whole service or the Director alone. The purpose in doing this was to share responsibility and awareness among those who were the most interested without having our regular meetings tied down with procedural decisions. The Management Board has been open to the membership of anyone on the HSICS staff who wishes to attend. We have met once or twice a month every month since our creation. Work responsibility and feedback have been shared at these meetings, although we have been unable to de-centralize to the degree originally envisioned.

It was agreed, though, that we still needed to have a Director as well as the Management Board. Three people (including myself), who thought that they had the time and energy formed a triad for directorship at the beginning of the summer of 1973. Due to changing priorities and situations (and the good fortune of my eligibility, though minimal, for compensation), I became the Director in July. I have held this position until May, 1974. I have worked about twenty hours a week during the past year.

Many HSICS staff members have given much more than their required three hours per week (the normal duration of a counseling shift). Twenty-five persons have worked with at least one Educational Outreach Program with Dusty Staub

and Wain Mengel volunteering ten to twenty hours a week as Coordinators. Six counselors have undergone extra training and given extra time to Problem Pregnancy Counseling (Minna Wiley has been the Coordinator). Several people have attended various meetings or given presentations as HSICS representatives. Counselors have met with counselees at times additional to their shifts. During our training program, ten members each gave twenty to forty hours during a two-week period. Alice Phalan has spent several hours a week as our treasurer, Lisa Buss Schultz has given many hours typing and editing this report and others for the Service. Vic Schoenbach, as Special Projects Coordinator, has initiated research and carried out several ideas of interest to HSICS. Many counselors in many ways have given time and energy to make our organization more fruitful in its ability to reach and respond to UNC and the surrounding community. Our Service has grown and strengthened as its members have chosen to assume a great deal of the leadership work that might have been done by a few.

As the Director, I have been the overall coordinator for many of the various functions and projects of our service, as well as designing and implementing some projects on my own. I have worked on the administration and planning of several tasks whose implementation I was not involved with (and have had to be a central information person for many projects that I did not work with directly). I have been the primary liason between the Service and other individuals and groups. Generally, this has meant attending meetings as the HSICS representative, responding to inquiries and giving presentations about the Service. Within my role as Director, I coordinated (and took much of the responsibility for) publicity, the planning of meetings, in-service education, and our screening and training program. I have tried to be easily accessible to every member of our Service for any ideas, concerns, projects, etc. that he or she might wish to discuss. I have also spent time with paperwork involved in finances and purchases (although someone else has been the HSICS treasurer). My orientation has been to develop as open and harmonious an organization as possible so that we would be able to serve the community with a minimum of internal friction.

I see the most effective behavior of the person in the primary leadership role of HSICS or a similar service as being that of a cohesive force internally and as a liason and representative to the greater community. I think that the leader should be available as a consultant and resource person

3. Genuine interest in the work that we are doing;
4. Works with us not primarily as a representative from another organization, but as a concerned individual;
5. Has a personality acceptable to Service members;
6. Is aggressive in his or her work to improve the quality of the Service;
7. Is sensitive to the needs of the campus and the community;
8. Is sensitive to the needs of Service members.

MEETINGS

Full service meetings have been scheduled for once every three weeks except when vacations conflicted (in which case we would meet before the duration of a three-week period rather than let a longer period of time pass before our whole team met again). Attendance is required (by a unanimous vote of the Service members) although no penalty has been invoked against those few people who missed meetings. People who were unable to attend a meeting were requested to talk with me about what had occurred.

The format that we have tried to follow has been: 15-30 minutes for business (which included projects that people were beginning as well as the development of those already underway, HSICS and medical/professional resource policy and changes, Management Board news); 15-30 minutes for the discussion of difficult, unusual, or significant counseling cases; a break, and approximately one hour for an in-service educational program (which has included films, professional presentations, group sharing and counseling skills experiences). Following this agenda has sometimes been difficult, but our meetings have always been open to the immediate input of any member as well as to suggestions for change and improvement.

Meetings for the entire organization are necessary for several reasons: an awareness of policy/procedure changes of our referral resources; whole Service decision making; increase of our counseling skills; increase knowledge about sexuality; learn of opportunities for work within the service,and; to become a more harmonious and sharing group.

QUALITY CONTROL

We have continuously worked to increase the quality of the services we provide. The screening and training program have been our principle method

(as all members should be to one another) and be aware of and responsible for coordinating the activities of the organization, whenever necessary. I believe that the greater the de-centralization of responsibility among the members of an organization similar to ours, the more dynamic and effective that organization is (certainly over a long period, if not immediately). I write this because of the tendency of Robert Wilson and me to assume responsibility when the membership could have fulfilled some of these tasks. As the Management Board and many individuals have continuously become more active, our service has become more cohesive and self-motivated. Jerry Noble, the new HSICS Director, has, as one of his goals, the further de-centralization of leadership functions and responsibilities.

FACULTY CONSULTANT

Bruce Baldwin, a Ph.D. psychologist who is on the staff of the UNC Student Health Service (SHS), has been serving as the Faculty Consultant to HSICS for almost two years. Bruce is given compensatory time for his work with the Service. He has been available to Service members and as a referral resource in a variety of capacities. I have met with him weekly to exchange ideas about the administration of the service, difficulties in our internal and external functioning, new directions, etc. He has met with various staff members to discuss counseling situations where his expertise has been requested, and, when counselors have not felt comfortable or able to deal with certain counseling situations, they have frequently referred people directly to Bruce. Bruce has given time and energy to many projects that HSICS members have been working on. He has served as a liason between our Service and the medical and mental health divisions of SHS. Bruce's awareness of and sensitivity to the campus community and to HSICS, as well as his genuine concern for helping people and improving the quality of our organization, have been strong impetus in our growth. His output (papers, presentations, etc) have increased the credibility and reputation of the Service while his input has increased the skill of its members.

A professional consultant/advisor can be effective without fulfilling all of the same functions that Bruce has. It is necessary, though, to remember that one is selecting a person not a professional. The following criteria were used in our search for a consultant.

1. Ph.D in psychiatry or psychology (or counseling-related field);
2. Willingness to devote two hours a week to working with counselors (more time is definitely needed);

of doing this. To become a member of HSICS, people not only must be willing to give time and energy, but also must meet the high, but fair, criteria which we believe shows that they will be effective as counselors.

Every counselor must fill out a data sheet for each person whom she or he is in contact with. The counselor should record the question or concern, what information was shared, the process and the outcome. These sheets are read by every counselor at the beginning of their shift. The counselors note any incorrect information, offer alternatives, or comment on their response to the particular situation. These sheets are left in the office for a month or so until each counselor can read the comments written by others.

An Evaluation Committee (Mike Petty, Ned Rice, and Judi Torrington) has been meeting every month to process all the data sheets and make specific suggestions and overall generalizations. The quality of write-ups (and seemingly of counseling contacts) has increased since this process began.

An evaluation sheet is given to participants during Educational Outreach Programs. The response has been very positive with some useful suggestions arising.

Confidential evaluation forms (with stamped self-addressed envelopes) are given to everyone who is involved in person-to-person counseling. The counselee is asked to fill this out after he or she leaves the office. We have consistently been rated good to excellent in all of these categories:

Rate your counselor's effectiveness in the following areas:

A. genuinely concerned with my problem or question
B. provided a relaxed atmosphere
C. knowledgeable of the subject matter
D. helped direct me to an answer to my question or problem
E. helped me to consider all possible aspects of the question or problem

Every respondent has replied yes to: Did the counselor provide adequate time to discuss your question or problem?

MATERIALS

Last summer, with a special grant from the Campus Governing Council, HSICS distributed 7,000 Birth Control Handbooks and 2,000 V.D. Handbooks (printed by Montreal Health Press, Inc, P.O. Box 1000, Station G, Montreal, Quebec, H2W2N1).

These booklets contain very complete and current information at a low cost (although they do contain an introductory political message). A small amount of publicity and a poster accompanied the dissemination of these booklets. Piles of them were put at central campus locations and in dormitories and, in less than a week, students had taken all of them. 450 questionnaires were distributed with some of them and of the forty-four respondents, only one thought that this was not a good use of their student activities' fund monies and most ranked these booklets very good to excellent. With this information and the visible rapid consumption of these handbooks, we requested 7,000 more of each booklet for the academic year 1973-74. These, again, were disseminated as rapidly as we could make them available.

In our office are shelves of pamphlets and books. The books have been collected from many sources, including SHS, pharmaceutical and contraceptive supply companies, medical resources, and health education organizations and publishers. Most have been given to us (upon request) although we have purchased some. All are available (except the most expensive) for people to take and keep. We also have a small library of papers, magazines and books that may be used while people are in the office or single items may be borrowed for a three-day period.

Since our beginning, we have been maintaining files from materials and articles that we have read. These items are primarily for the use of our counselors, but are also available to anyone who needs them.

We regularly compile and update a list of area resources and their services and fees. We do this by initially writing to every area resource requesting information. Those who do not respond are then contacted by phone until we have been able to obtain the information necessary. What we ask each resource for is: types of services; qualifications for eligibility; cost (if any); time services are available (hours and days); type and size of staff; address and telephone number; director or contact person(s); and any additional information, and, specific to that particular resource all of the information is compiled and condensed into a handout that is distributed to every HSICS member. The information is updated as changes occur.

PUBLICITY

Our Service has received publicity from a variety of sources. When we began, a number of national magazines gave us news coverage. In the past year, local newspapers and radio and television stations have done stories about us and/or given us free publicity. Every area media resource has been glad to give us some free publicity as a public service.

We have printed and distributed posters describing our Service in campus and community buildings. Every *Birth Control* and *VD Handbook* that we disseminated had our name stamped on the cover. In the past, we distributed brochures describing the HSICS to dormitory residents and in other campus buildings. With every publicity campaign, the number of people using the Service has immediately increased.

SEMANTICS

The importance of word choice has become increasingly apparent as our sensitivity to those whom we help has grown. Most people who utilize our service are in their late adolescence or older. I consider and refer to these people as men and women, not "boys" and "girls" unless they choose to call themselves otherwise. I think that a person who believes him or herself to be a man or a woman (whatever the nebulous division between child and adulthood may be) can be alienated and feel belittled by a counselor or educator referring to them as a boy or girl. I have checked this out with many people who agree. HSICS counselors have also begun substituting words like question and concern for problem in order to make counselees feel more comfortable and less like something is wrong with them.

Although our goal is *not* to alter our clients' language, it is to be more in touch with word useage that will put them at ease. Within this context, we try to use the words that they use in describing their sexuality organs and acts, rather than correcting slang or using technical/medical terminology that may not be understood. Being sensitive to words and people's feelings about words is very important and demands a constant and high level of awareness.

CAMPUS AND COMMUNITY CHANGES

On the UNC campus, some changes have occurred that have begun to meet the sex-related needs of students. The Student Health Service has offered a Women's Health Clinic to women students two nights a week. Students have found it easier to obtain contraception and treatment for their sexual concerns from medical doctors and have received skilled non-judgmental counseling from the Mental Health staff (although both divisions of SHS are seriously hampered by the small size of their staff). Dormitory residence assistants have received training in sexuality counseling. Freshmen orientation has (and will to a greater degree) included discussions and information about relationships and sexuality. Dormitory residents are allowed to determine the visitation policies of their homes. Courses on sexual topics have become more accessible (though limited).

Within the community, some medical resources have expanded their services. A very limited number of menstrual extractions, as well as abortions, are available at the North Carolina Memorial Hospital. Abortions are accessible throughout North Carolina. In general, though, a majority of the medical profession has been unresponsive to the sexual needs of the people who use their services. The major hospital in the area (North Carolina Memorial) functions primarily as a teaching center rather than as a service center. We hope that this pattern will alter and we are working toward the goal of increasing the responsiveness of the medical professional to the people who need and utilize their services.

FUTURE DIRECTIONS

Jerry Noble

The dynamic nature of HSICS is obvious to the perceptive observer. Our organization was born in response to several sex-related needs of our community; now, we constantly adapt our approach in providing informational services to the community as those needs themselves evolve. Flexibility and responsiveness, then, are key elements in the success of any peer sex service.

Despite our commitment to respond as necessary to our community's needs for sex-related health services, as they develop, an estimation of the directions in which HSICS is and should be headed is certainly possible. Before discussing these, I must point out that to a considerable extent these goals are a reflection of my personal priorities as I begin my tenure as Director of HSICS. On the other hand, I owe much of my enthusiasm for these future directions to the fellow counselors who have proposed and supported each with such vigor. The staff commitment behind each of these goals is impressively broad as I have attempted to gauge it.

The following are eight areas in which I foresee definite trends in the directions HSICS will be pursuing during the coming months:

1. Health consumer advocacy. In the past, HSICS has often acted as an advocate for the health consumer by helping mediate between the consumer and extant health services. Nevertheless, this role has only recently been articulated by HSICS staff as one of our most improtant functions and a commitment been made to formalize and intensify our efforts to act as a health consumers' advocate. One of the first projects designed to realize this function is now underway, an effort to have the student health service distribute, as a matter of policy, an informational sheet about the risks and side effects of the "morning after treatment".

2. Short-term counseling. As noted previously, contact by HSICS staff with counselees has usually been limited to a single session, whether by telephone or on a walk-in basis. Our staff is generally agreed that the one-session nature of the typical HSICS intervention is due to the fact that the availability of continuing counseling relationships has not been publicized. The need for such short-term counsleing is obvious in the face of a shortage of professional counselors in the area. Furthermore, the ability of HSICS staff to meet that need has increased strikingly as extant personnel have acquired new expertise and as new personnel have been progressively more qualified. The formal addition of a service such as this is not one to be taken lightly. Consequently, additional screening and training will be utilized to insure the competency of those counselors wishing to do short-term counseling.

3. Expansion of non-remedial functions. The remedial nature of most services HSICS has rendered in the past is obvious. For the most part, the information and/or counseling staff has offered in one fashion or another has been problem-oriented. In recent months, the Outreach functions HSICS has performed have been more toward providing experiences that will allow individuals to realize unfulfilled potential. Further steps in this direction are certain to follow, possibily in the form of HSICS-sponsored personal development experiences using variations of encounter and/or consciousness-raising models.

4. Independent financial support. One of the key assets of HSICS has been its nominal operating costs. Thus far, adequate financial support has been available from the student legislature. However, as HSICS continues to expand in scope, permanent dependence upon student government appears to be unwise. Other sources of financial support should be explored so that HSICS may continue to evolve in a natural fashion. Particularly necessary are funds for support of leadership positions. Dedication of 20-40 hours per week to perform the responsibilities of HSICS Director is not a commitment many individuals can realistically make without some kind of financial support. Finding a highly qualified individual to do so is an even more difficult task. However, the directorship is not the only position that seems to require some level of compensation. As HSICS continues to expand in scope and specialize in function, more individuals will be required to make commitments to other areas of responsibility, commitments which should be matched by financial support. An excellent example of this additional need is the situation that occurred this past semester in which our Outreach Coordinator, Dusty Staub, averaged roughly 20 hours per week with Outreach responsibilities alone.

5. Decentralization of leadership. In its early stages, HSICS thrived under the leadership of Robert Wilson, who devoted 20-60 hours per week in the performance of his responsibilities. Our recent Director, Robert Diamant, averaged 20 hours per week. This decrease, however, does not reflect a decline in the need for person-hours committed to leadership functions. Indeed, if anything, that need has increased as HSICS has assumed new areas of responsibility. These new functions have, by nature, been increasingly specialized, a state of affairs which reduces the likelihood of a single individual being able to administrate such disparate programs and projects effectively. Decentralization of leadership responsibilities is clearly in order. Such decentralization will also preclude an undesirable situation in which one or a handful of individuals "carry" HSICS leadership-wise.

6. Academic credit for counselors. HSICS has never been an organization whose staff has typically volunteered the minimum amount of their time and energy, two-three hours for their weekly counseling shift. Many counselors have consistently expended 6-15 hours per week without compensation. This expenditure of time has been a sacrifice for many individuals. Consequently, easily available academic credit for those counselors who are students would allow more staff members to give even more person-hours than is presently the case.

7. Increased research activity. HSICS is in a unique position in that data concerning sexual behavior on this campus is easily available and that additional data could be easily drawn. To this point, however, HSICS has not made a commitment to draw upon this data systematically as an organization for research purposes. What research has been performed has been executed

by a handful of individuals and generally for purposes instrumental to extant HSICS functions. HSICS has an obligation to conduct research in areas in which it is peculiarly suited to do so. One such area is the question of what kinds of individuals become peer counselors (a question for which we have answers, but not in psychometric form). Intensified research activity would also contribute significantly to the credibility of our organization as "a unique and quality alternative".

8. Ties with other peer sex services. In the past, HSICS has had contact with other peer sex services primarily in the context of assisting these services being initiated. The success of our model and of others has demonstrated the desirability of large-scale founding of peer sex services. However, to facilitate this goal, intensified dialogue between extant peer sex services is indispensable to construction of a common identity that will be a force with which to be reckoned in the course of future discussion of health service delivery modalities.

APPENDIX I

STATISTICS ON SERVICE UTILIZATION

Utilization Patterns by Semester Since Inception of the Service*

SERVICE CATEGORIES	SPRING, 1972				FALL, 1972				SPRING, 1973			
	M	F	Total	%	M	F	Total	%	M	F	Total	%
Contraceptive Information/Referral	57	123	180	21.1	117	193	310	31.4	84	151	235	26.5
Pregnancy Information/Referral	48	69	117	13.7	61	90	151	15.3	50	87	137	15.4
General Information Human Sexuality	70	64	134	15.7	49	61	110	11.2	40	50	90	10.1
Abortion Information/Referral	63	68	131	15.4	33	50	83	8.4	55	36	91	10.3
Disease/Infections/Ailments	48	23	71	8.3	63	30	93	9.4	66	28	94	10.6
Marital/Inter/Intrapersonal Problems	23	25	48	5.6	32	26	58	5.9	38	16	54	6.1
Book Requests/Research Information	30	29	59	6.9	11	29	40	4.1	25	22	47	5.3
Reproductive Physiology/Sexual Techniques	31	18	49	5.8	26	19	45	4.6	26	23	49	5.5
Sexual Dysfunction	2	12	14	1.7	26	12	38	3.9	27	7	34	3.8
Homosexuality	32	2	34	4.0	21	7	28	2.8	25	3	28	3.2
Speakers/Discussion Leaders	5	10	15	1.8	1	9	10	1.0	7	15	22	2.5
Prank/Crank Calls	0	0	0	0	12	1	12	1.3	3	0	3	.3
Legal Information	0	0	0	0	5	2	7	.7	1	3	4	.4
TOTALS:	409	443	852	100 %	457	529	986	100 %	447	441	888	100 %
Student Contacts/Semester Week*	25.6	27.6	53.3		28.6	33.1	61.7		27.9	27.6	55.5	

APPENDIX I Continued

STATISTICS ON SERVICE UTILIZATION

Utilization Patterns by Semster Since Inception of the Service

SERVICE CATEGORIES	FALL, 1973		SPRING, 1974	
	Total	%	Total	%
Contraceptive Information/Referral	174	20.7	89	15.8
Pregnancy Information/Referral	120	14.3	88	15.7
General Information Human Sexuality	138	16.4	90	16.1
Abortion Information/Referral	106	12.6	57	10.2
Disease/Infections/Ailments	90	10.7	47	8.4
Marital/Inter/Intrapersonal Problems	55	6.5	30	5.3
Book Requests/Research Information	30	3.5	37	6.6
Reproductive Physiology/Sexual Tehcniques	32	3.8	25	4.6
Sexual Dysfunction	25	3.0	24	4.3
Homosexuality	42	5.0	40	7.1
Speakers/Discussion Leaders	24	2.9	25	4.6
Prank/Crank Calls	4	.6	8	1.3
TOTALS:*	840	100 %	560**	100 %
Student Contacts/Semester Week	52.5		40.0	
Walk-ins	204		155	
Calls	622		395	
Correspondence	14		10	

* During this year (September, 1973-May, 1974), we have been in contact with an additional 1,400 people through our sex education Outreach Programs.

** Represents a 14-week (as opposed to 16-week) semester.

APPENDIX II

SOME MATERIALS FROM SCREENING AND TRAINING

From the second page of a two-part application form.

1. As you perceive them, please describe your strengths and weaknesses in talking with and relating to other people.

2. What does sexuality mean to you?

3. Please define yourself, in whatever manner you like, in terms of your sexual identity.

4. Why have you chosen this time in your life to be involved with this type of work?

Sex autobiography instructions.

This task invited you to write a short autobiographical sketch of your sexual development in terms of attitudes, beliefs, fantasies, feelings, experiences, and education that were significant because of what did or did not happen. The following is not intended as an outline, but you might touch upon: early sex learning, experiences with masturbation, intercourse, homosexuality, group sex, problems in sexual functioning or relating, relationships with parents, siblings, personal values and attitudes, etc. You will not have room to bring in all of these things, of course, so you may want to select those that were most significant in your own life. While we encourage you to include specific experiences, no one should feel under pressure to reveal things that he or she does not wish to. Furthermore, your feelings about sexual behaviors that you have not engaged in may be just as important or more so than describing those you may have engaged in. We want this to be an opportunity to tell about your sex/love life as you want to present it.

You have one half an hour to do this. You may write on both sides of the sheet (please print legibly). When we are finished writing this, we will divide into small groups and anonymously share and respond to these.

Dimensions of Interpersonal Response

Many dimensions can be defined on which to assess differences between individuals, as well as in determining the effectiveness of interpersonal or "helping" relationships. The following dimensions of interpersonal response might be used as a general guide in looking at how certain individuals respond to others. Each dimension is presented as a bi-polar. On the left are

those responses which seem to facilitate sound helping relationships and on the right are those responses which are not as helpful in such relationships.

1. listening more than speaking vs speaking more than listening
2. maintaining good eye contact vs avoiding eye contact
3. use of non-question responses vs reliance on direct questioning
4. number of open-ended questions vs number of closed questions (answered yes, no)
5. response to both content and feelings of client verbalizations vs response only to content (i.e., seeking only objection information about client)
6. acceptance of other person and non-judgmental responses vs evaluative, judgmental responses (i.e., the helper's values are showing!)
7. full exploration of both situation and alternatives vs early "advise giving"
8. creation of an egalitari n helping relationship vs creation of an authoritarian relationship
9. appropriate self-disclosure vs excessive self-disclosure or role-reversals (i.e., "Let me tell you what happened to me!")
10. appropriate use of a comfort with silence vs maintaining continued verbal activity
11. comfort with and ability to use sexual terminology vs embarrassment with or avoidance of such terms
12. maintaining some objectivity in responses to other person vs excessive involvement in others' problems
13. ability to listen effectively and accurately vs making responses irrelevant to the other person's needs (i.e., helper responding to self rather than to other person)
14. allowing decisions by other person vs imposing helper's decisions

(This part of our training program was adapted from materials which Bruce A. Baldwin, Ph.D., has developed.)

The Peer Counselor: Identity in the Helping Triad

Person to person counseling is a relatively new concept in helping relationships. Peers have been effective in many situations requiring intervention by another person. However, it is essential for the peer counselor to define himself/herself, particularly in reference to similarities and differences between "friends" on one hand and "professionals" on the other. Use the following diagram to help define the unique aspects of each of the three major categories of helpers (friends, peer counselor, professionals) as well as the commonalities shared by them.

Unique

____
____
____
____
____

Peer Counselor

Common
Qualities

______
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Friend - unique

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Professional - unique

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(Also adapted from materials which Bruce A. Baldwin, Ph.D., has developed.)

APPENDIX III

TRAINING IN SMALL GROUP FACILITATION FOR OUTREACH PERSONNEL

Presented March 21, 1974

This program was initiated by the Director of HSICS and the Outreach Coordinator. The initial planning sessions numbered three and the last two sessions took over two hours. The first session outlined the needs of the outreach staff for greater expertise and training in small group facilitation. This led to an initial meeting with members of Dr. Eugene Watson's Education class on group processes. The two meetings with these members were attended by the Director and the Outreach Coordinator. Feedback from counselors in outreach was sought as to the skills they felt deficient in and problems they had faced when leading small groups. It was decided that the most effective program would be one that combined a) modeling of facilitator role, b) an experiential learning situation, c) a discussion and presentation for theory and methods of facilitation. Due to a lack of time on the part of the counselors, this model was designed as a one-session package taking three hours.

Fifteen people attended this training program. A blind mill was the initial exercise. This was done in order to increase the anxiety level and sensitize the members for the task discussion. This took ten minutes: the members closed their eyes and moved in a tight circle, touching one another and communicating non-verbally. The discussion that followed centered on the feelings generated during the blind mill. Surprisingly, members really enjoyed the experience and there was a real sense of closeness following the mill.

Educators from Gene's education class modeled as facilitators for the discussion centered on the feelings and thoughts concerning the touching experience and group discussion. Five members of the class also sat around the perimeter of the circle and observed the discussion and noted the flow of the group and effectiveness of the facilitators. This took 45 minutes.

Summation of the process was given by the group and the facilitators. Also, there was a brainstorming session in which areas of concern and topics on group processes were listed on a blackboard. These topics were later used to direct the form and topics of the presentation and discussion of group facilitation. A ten-minute break followed. The brainstorming lasted 20 minutes.

The final phase of the program occured after the break. This lasted slightly over an hour. The observers gave their feedback to the group and to the facilitators, with interruption and discussion occuring when evoked. Finally, members of the education class explained group theory: thesis, antithesis and synthesis, etc. and related it to the previous discussion experience, pointing out examples of "the handclasp", "gate-keeping", etc. Then techniques and skills were discussed with question and answer period at the end.

The experience of an actual encounter and discussion coupled with the presentations was felt to be invaluable and an integral part of an effective program on group processes and facilitation.

APPENDIX IV

TWO OUTREACH PROGRAMS

I. Ephesus Church Road Elementary School Sex Education Model, Jerry Noble.

This particular outreach effort was comprised of three separate sessions with a class of twenty-five 10-11 year olds. Before any of these sessions were planned, the class's teacher surveyed her students informally to evaluate the relative importance of various sex-related concerns.

Several preliminary planning sessions between Outreach personnel and the teacher followed and resulted in conception of a unifying theme to the proposed Outreach presentations. This theme was "What It Is to Be Growing Up".

In order to realize this theme, teams of male and female facilitators worked with subgroups of the class. Each facilitating team consisted of male and female, two males or two females as appropriate to each session. In each session, presentations with varying degrees of formality were done by team members who complemented each others' tasks. In all cases, an effort was made to encourage and answer all questions arising in the course of presentations. The class was aware of the opportunity to submit anonymous written questions, an opportunity designed to meet the needs of those less eager to explore salient concerns orally. Discussion time was set aside at the end of each session, again to encourage and answer questions stimulated by the presentations. Finally, the mode of presentation was flexible in that facilitators readily adapted to the expressed needs of the class in terms of how and which topics were to be handled.

Descriptions of the three sessions follow:

Session 1: Presentations were made on male and female anatomy and physiology, using charts and diagrams. Male and female members of each team alternated in discussing the basics of the male and female reproductive systems.

Next a terminology game was used where the technical terms of reproductive organs and forms of sexual expression (i.e., intercourse, masturbation, etc.) were listed one by one on a diagram. The facilitators then asked the children, "What do you call this?" This exercise served three purposes: 1) the class was familiarized with the technical terms; 2) the shock value of sexual slang was reduced or eliminated ("dirty" words were no longer dirty); and 3) confusion about the terms for certain organs or forms of sexual expression was reduced.

Finally, a discussion about intercourse was conducted, centering around the questions: What it is? Why it is? Examples from the animal kingdom were used as well as description of the human process. An attempt was made to communicate some of the reasons people have intercourse. Intercourse was treated as a bodily function and was not moralized. Responsibility to and respect for the privacy of others were stressed.

Session 2: This session focussed around childbirth and pregnancy. Two films, Boy to Man and Girl to Woman were shown prior to this visit as a useful transition between the first two sessions. Another film, Fertilization and Birth, was shown at the beginning of the session.

Afterwards, subgroups of the class met with facilitators for discussion. Oral questions were again encouraged as the prime intent was to stimulate dialogue, both between students and facilitators and between students.

Women facilitators talked about feelings and body changes that occur during pregnancy. Contraception was raised breifly and pregnancy as a consequence of unprotected intercourse was stressed.

Session 3: This session centered around the facts, fears, and feelings related to masturbation as well as a clarification of any covert expectations the facilitators might have communicated.

The facilitators' expectations were articulated in this manner: information is necessary for responsible sexual decision-making. That information is also necessary to resist pressure exerted by others to be sexually active or inactive.

Prior to the initiation of the Ephesus Outreach, the Chapel Hill School System's curriculum on family life education was reviewed in order to insure the compatibility of the planned presentations. This curriculum contained many ideas that the facilitators kept in mind throughout the subsequent presentations:

1. Values should not be taught.
2. Girls and boys may have different feelings about themselves as they grow older.
3. As boys and girls grow older, their feelings towards others change.
4. Bodily functions and human emotions are inter-related.
5. Sexuality is a part of personality.
6. Boys and girls mature at different rates.
7. As boys develop into men and girls into women, they change in many ways.
8. Comparisons between plant and animal reproduction should be drawn.
9. Sex helps make us what we are (genetically at conception; interpersonally in later life.)
10. A very desireable goal is the alleviation of fears and anxieties related to sex and sexual development.
11. Body changes are a part of growing up.
12. Sex education is a subgroup of the larger realm of family life education.

Other ideas Outreach personnel were conscious of throughout the Ephesus experience include:

1. Sexuality is part of personality; it helps make us what we are.
2. Do not preach: avoid trying to tell them what values to hold.
3. Positive and accepting attitude towards sexuality should be communicated.
4. Body changes are a part of growing up.
5. It is desireable to alleviate fears and anxieties related to sex and sexual development.
6. Don't talk down to the children or past them.

II. Outreach Program Format for First-year Medical Students.

Dr. Robert Lawrence requested a program in Human Sexuality for his freshman medical class. The Outreach Coordinator and another counselor met with Dr. Lawrence to find the best possible program to help the students explore their sexuality and feelings. There had been criticism expressed by class members that the medical school had failed to provide opportunities for exploration of attitudes and feelings. It was decided to utilize a two-step program: first, to distribute a questionnaire that would allow students to ananymously express their feelings on topics listed in the questionnaire and, secondly, to provide facilitators for small group discussions the week following the distribution of the questionnaires. Of the 110 questionnaires distributed, only 36 were returned, yet, 65 students of a class of 116 participated in the small group discussions of their feelings and sexuality. The questionnaire was used as a tool in the groups by the facilitators.

HUMAN SEXUALITY QUESTIONNAIRE FOR FIRST YEAR MEDICAL STUDENTS

1. What kinds of sexual concerns do you have about yourself and/or your relationships or lack of relationships?

2. What sexual topics do you discuss with your sexual partner(s)? What do you hesitate to ask or talk about?

3. What is your feeling response to masturbation?

4. Have you ever masturbated?
   a. with what frequency?
   b. when did you begin?
   c. how important is masturbation in terms of your sexuality and why?

5. Have you ever had any difficulty with sexual functioning, such as:
   a. difficulty in attaining orgasm?
   b. premature ejaculation?
   c. impotence?
   d. painful intercourse?
   e. other?

6. How would you feel if your girlfriend or wife wanted an abortion? or How would you feel if you were pregnant?

7. What factors would contribute to your decision about the pregnancy?

8. What is your feeling level response to homosexuality?

9. What common characteristics do most homosexuals have?

10. Do you fantasize making love with a person of your sex? Explain.

11. Describe the closest relationship you have had emotionally or physically with someone of your sex.

12. How do you feel when people assume that you are sexually active? How do you feel when people assume that you are sexually inactive?

13. What does promiscuity mean?

14. Have you ever viewed yourself as promiscuous?

APPENDIX V

SOME TECHNIQUES USED BY OUTREACH TEAMS

The following techniques have all been utilized by Outreach members with success. One key factor, though, is that the techniques must be creatively used. A good sex educator has a feeling for the participants and can spontaneously "decide" on a method to help bring a group together. These techniques are more guidelines than rules. The only real rules are: know your topics and prepare beforehand. These techniques have evolved from counselors, been extracted from books and periodicals, borrowed from friendly professionals, and finally, been suggested by the situations and groups with whom HSICS Outreach has been involved.

1. To promote discussion, slips of paper were passed out to participants of some presentations and they were asked to write down a question on an area of concern. These questions were then redistributed to the members and the person who had a question in front of him/her that seemed interesting would read the question aloud. This promoted cohesion and got people into the habit of verbalizing.

2. People were asked to anonymously write a scale from 1 to 5 and to circle one of these numbers if 1 equaled being a virgin, 2 virgin but petting, 3 intercourse a few times with one partner, 4 intercourse with more than one partner or many times, and 5 some experience with group sex. These were tabulated during a break and presented to the participants as a scale of sexual experience. This method did wonders in promoting discussion and was always a real eye opener for participants who were surprised at the statistics.

3. Rhetorical questions to promote thoughtfulness: How would you feel if....

4. Jokes: using the situations that arise naturally in discussion to lighten the mood and help relax the participants.

5. Turning the question back to the audience: "That's a tough one. Any ideas?"

6. Relating the answers to questions from the audience to the topic areas and concerns that they expressed in the pre-program questionnaires.

7. "Close your eyes and visualize: your first sexual experience. What feelings did you have? Were you nervous, guilty? Visualize your present state. How do you feel about yourself? Your sexuality?"

8. Relate the topic to other cultures: taboos and sexual mores are different, for example: the aborigenes in Anhemland in Australia have no rules against pre-marital intercourse and encourage children to engage in sex play, but they have very strict taboos against talking to a marriagable young woman and against a daughter-in-law speaking to the mother-in-law. The law concerns the vocal organs not the sexual organs.

9. Role playing: emphasize the immediate situation and provide positive feedback with modeling behaviors and practice.

10. Small group discussions: break a large group into a smaller one.

11. Plant a sensitive question if it isn't asked by having an observer in the audience ask it.

12. Be honest and open about where you are and where you are coming from. Stress acceptance and a positive attitude concerning human sexuality.

13. Brainstorming for questions and answers.

14. Ask the audience to consider what is important to them, what they like and dislike. Where are you?

15. Sharing a bit of yourself, "personal revelation", this will help create more trust and openness on the part of all present.

16. Know and be comfortable with your feelings on certain issues. If your feelings are that you are uptight on a particular topic, it is a good idea to let someone else deliver the program.

17. Confidence is necessary; it is communicated to the participants and helps in the presentation and discussion as well as relaxing the audience.

18. Point out the alternatives in contraception and behavior and help relieve initial tensions with a short presentation of factual information.

19. Give the participants a chance to mix and talk to one another.