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HEALTHY SEXUALITY: EVALUATING A PSYCHOEDUCATIONAL GROUP
PROMOTING KNOWLEDGE, COMMUNICATION, AND
POSITIVE EXPERIENCES

by

Brenna Wernersbach

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Psychology

Approved:

Renee V. Galliher, Ph.D.
Major Professor

Susan Crowley, Ph.D.
Committee Member

Scott Bates, Ph.D.
Committee Member

M. Scott DeBerard, Ph.D.
Committee Member

Julie Gast, Ph.D.
Committee Member

Mark R. McLellan, Ph.D.
Vice President for Research and
Dean of the School of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

2013

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ABSTRACT

Healthy Sexuality: Evaluating a Psychoeducational Group Promoting
Knowledge, Communication, and Positive Experiences

by

Brenna M. Wernersbach, Doctor of Philosophy

Utah State University, 2013

Major Professor: Renee V. Galliher, Ph.D.
Department: Psychology

The present study examined the state of healthy sexuality among college students and the influence of a psychoeducational group on related constructs. Healthy sexuality is comprised of multiple constructs, including accurate knowledge, positive attitudes, risk-reducing behaviors, open communication among partners, and self-efficacy for creating desired experiences and preventing unwanted experiences. Sexuality-related knowledge, attitudes and values, and behaviors were measured prior to and following the four-session intervention. Additionally, prior sexuality education at the familial and school-based levels was assessed and compared to the designed intervention. Fifty-six young adults participated in the groups, with topics covering sexual anatomy and response, communication, safer sex practices, and preventing unwanted experiences.

Assessment prior to the designed intervention exemplified the wide variety of educational experiences and sources that young adults have, contributing to great

variation in sexual knowledge, attitudes, behaviors, and self-efficacy. Participants reported varying levels of satisfaction with their sexuality education prior to the intervention, but satisfaction was unrelated to knowledge accuracy. Attitudes, values, and behaviors were similar to national samples. Assessment following the intervention demonstrated significant improvement in many of these areas, indicating that college students are likely to benefit from continued sexuality education. The level of interest for participation in the study indicates young people's interest in increasing healthy sexuality in their lives. It is hoped that the designed intervention may continue to be made available to young adults and tailored to meet their needs and desires as appropriate.

(234 pages)

PUBLIC ABSTRACT

Healthy Sexuality: Evaluating a Psychoeducational Group Promoting
Knowledge, Communication, and Positive Experiences

by

Brenna M. Wernersbach, Doctor of Philosophy

Utah State University, 2013

Although most people will have at least one sexual relationship throughout the course of their life, many of us have not developed the skills we need to create the sexual experiences that we really want. This is influenced by (among other things) our sexual knowledge, our attitudes and values about sex, our ability to communicate clearly and effectively with our partner(s), and our access to sexual and reproductive health services and products. Accurate knowledge, positive attitudes, and self-efficacy in communication and resource access are all contributing factors to what is known as healthy sexuality.

The present study examined these areas before and after a four-session group that was designed to increase aspects of healthy sexuality among young adults. Participants reflected on their sexuality education histories (including family, peer, and school influences) and compared those experiences with their experiences in the designed group. Measurements of knowledge accuracy, attitudes and values, and various behaviors indicated a wide variety of experiences prior to the group, and significant improvement in many areas following participation. It is hoped that the psychoeducational group will continue to be offered to young adults on college campuses and that it may be modified for use in other settings such as church, community, or after-school groups.

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I also thank the many offices on campus that supported this project throughout its stages of development, including the Utah State University (USU) Student Health and Wellness Center, Sexual Assault and Anti-Violence Information (SAAVI) office, and Access and Diversity Center, particularly LGBTQA Programs. I would especially like to thank USU Counseling and Psychological Services (CAPS) for their support as this project evolved from a class project into a two-workshop series, and finally the four-session group described here. CAPS support in advertising, recommending, and providing meeting space for the groups was integral to the project's success.

Most of all, I thank the students on campus who were so receptive and supportive of this project. This includes the individuals who brought to my attention the need for

such a group on our campus, the students who passionately helped spread the word about the project early in recruitment, and the Voices for Planned Parenthood (VOX) student group that donated supplies for the safer-sex starter kits. Above all, I sincerely thank the participants for their commitment to this project. In addition to giving me a great deal of their time, they shared their questions, experiences, ideas, and unique perspectives throughout this process, enriching the groups for each other, for the future, and for me. I can only hope the groups gave as much to them as they gave to me.

Brenna M. Wernersbach

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CHAPTER I

INTRODUCTION

Despite the so-called sexual revolution of the 1960s and 70s, sexuality (the expression of sexual behavior) remains a highly taboo subject among many Americans. Although it is not something that is often discussed openly, the majority of individuals will experience some form of sexual encounter during their lifetime (Fox & Inazu, 1980; Hutchinson & Cooney, 1998; Meschke, Bartholomae, & Zentall, 2000). Sexuality education for youth remains inconsistent and incomplete, and approaches to sexuality in psychology are typically focused on sexual assault and/or sexual dysfunction (Hutchinson & Cooney, 1998; Kirby et al., 1994; Landry, Kaeser, & Richards, 1999; Lindberg, Santelli, & Singh, 2006; Rosenbaum, 2006, 2009). This shroud of secrecy prohibits young adults and adolescents from making well-informed decisions about their sexual behavior, and leads to a great deal more learning by trial-and-error than is necessary based on the amount of knowledge that exists about healthy sexual functioning (Chilman, 1990; Weiser & Miller, 2010). Although there is a great deal of variability in the literature with regard to the definition of healthy sexuality among adolescents and young adults, attempts at definition have been addressed by multiple sources (see Chapter II for a more detailed discussion of definitions of healthy sexuality). These definitions emphasize an individual's ability to make informed decisions and act on them effectively, requiring accurate knowledge, adequate levels of sexual self-esteem and sexual self-efficacy, and communication with one's partner(s) (Edwards & Coleman, 2004; Lottes, 2000; Robinson, Bockting, Rosser, Miner, & Coleman, 2002; World Health Organization

[WHO], 1975).

In addition to the prevention of unwanted consequences of sexual activity (e.g., sexually transmitted infections, unplanned pregnancy), healthy sexuality links to many positive aspects of well-being, such as self-esteem, self-efficacy, and relationship satisfaction. Individuals with higher levels of self-esteem tend to be less emotionally impacted by the demands of others (e.g., guilt or anxiety about meeting other-imposed standards of behavior) and have greater behavioral self-control (Chilman, 1990). This perception of control, or self-efficacy, contributes to lower levels of sexual anxiety and higher levels of sexual self-awareness and sexual subjectivity (in contrast to sexual self-objectification; Horne & Zimmer-Gembeck, 2005). Individuals with higher levels of sexual self-efficacy also report greater ease engaging in sexual communication with partners, including discussion of sexual likes and dislikes, which contributes to higher levels of sexual satisfaction and sexual well-being (MacNeil & Byers, 2009). This serves to shape one's sexual experiences in such a way as to better align with personal desires and further contributes to enhanced intimacy within relationships (Byers, 2011).

The majority of college students (77.6%) report being sexually active in their lifetime and 72.1% report having been sexually active within the past 12 months (University of Minnesota, 2007), yet discussions of whether or not college students' experiences may be considered "healthy" according to the definitions of healthy sexuality are rare. Based on the questionable nature of recent abstinence-based public sexuality education, how much sexual knowledge do current college students hold and how much of that is accurate (Rosenbaum, 2006, 2009)? What have been their primary sources of

information with regard to sex? What influences have their families and peer groups had on their knowledge and attitudes about human sexuality? What sexual behaviors are they engaging in, and what is their level of self-efficacy for creating the experiences that they desire and preventing the experiences they do not desire?

One goal of the present study was to answer these questions by asking college students to reflect on their sexuality education histories and their satisfaction with this educational history, including school learning and family and peer influences.

Furthermore, the project addressed levels of knowledge, attitudes, and behaviors in college students to evaluate the extent to which typical college sexual experiences align with definitions of healthy sexuality drawn from the literature. Although a handful of sexuality education programs have been designed with college students in mind, few of these formally address all (or any) of these constructs.

In addition to this basic descriptive query, the study aimed to bolster healthy sexuality among young adults through increasing accurate knowledge, positive attitudes about human sexuality, and self-efficacy in communication and behavior. A multi-session psychoeducational group was designed with the goal of improving accuracy of sexual knowledge, allowing participants to explore and strengthen their own values and attitudes, and increase self-efficacy and skills for creating desired experiences. By using a within-subjects test-retest design as well as a waitlist control group, the effectiveness of this intervention was assessed. Participants were asked to evaluate this program in the same manner they had evaluated their previous sexuality education for comparison.

CHAPTER II

REVIEW OF THE LITERATURE

This review of the literature is organized into three primary sections. First, an introduction to the construct of healthy sexuality is presented, including proposed definitions and further examination of some of its components such as knowledge, behavior, sexual self-esteem, sexual self-efficacy, and communication. This is followed by an overview of American trends in sexuality education, including familial influences and public education, as well as recommendations for sexuality education. The review concludes with the rationale, purpose and objectives for the current study.

Healthy Sexuality

Healthy aspects of sexuality are inconsistently emphasized in sexuality education and psychological research. Some models of sexuality education conceptualize sexuality itself exclusively within a negative context (DiMauro, 2000) and sexual behavior has often been discussed only in terms of risky behavior, negative consequences, and dysfunction (Hutchinson & Cooney, 1998; Kirby et al., 1994). Certainly, great variability exists in the quality and inclusiveness of sexuality education programs, with programs ranging from “abstinence only” models to more thorough comprehensive sexuality education models. However, the widespread focus on restriction of sexuality present in many sexuality education programs contributes to the taboo surrounding human sexuality, particularly when it comes to adolescents and young adults. This focus, in turn, limits positive portrayal or dissemination of information regarding healthy sexual

experiences and development (Chilman, 1990).

Definitions of Healthy Sexuality

A number of definitions of sexual health have emerged over the past few decades (see Table 1, Edwards & Coleman, 2004). Across these definitions, sexual behavior is viewed as a natural and positive part of the human experience. None of the definitions indicate an “age-limit” in terms of when healthy sexuality “begins” in the lifespan, yet adolescent and young adult sexuality continues to be policed by cultural attitudes, rules, and fears. In spite of messages emphasizing the superiority of abstinence as a safe-sex practice for adolescents and emerging adults, the majority of young adults in the United States are sexually experienced: 70% of females and 62% of males report having had intercourse by age 18, and by age 21 those rates increase to 81% and 85%, respectively (Mosher, Chandra, & Jones, 2002).

Chilman (1990) argued that adolescent sexual behavior is not inherently problematic: this evaluation must be based on factors such as the norms of the adolescent’s familial and peer groups, the use or omission of devices for prevention of pregnancy and sexually transmitted infections (STIs), and the nature of the experience. Chilman’s definition of sexual health emphasizes the importance of open communication, personal acceptance of one’s own sexual desires, and consideration of one’s values and goals as well as those of significant others. For most people, this requires examining familial and cultural values regarding sexuality and determining which of those values are personally valid. Further, Chilman warned that without such understanding and acceptance, individuals may “overcontrol” their sexual feelings and behaviors, which

Table 1

Definitions of Sexual Health as Reported by Edwards and Coleman

Source	Definition
WHO Technical Reports Series (1975)	Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.
SIECUS (1999)	Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful ways; and express affection, love and intimacy in ways consistent with one's own values.
Pan American Health Organization, World Association of Sexology (2001)	Sexual health is the experience of the ongoing process of physical, psychological and social-cultural well-being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld.
Lottes (2000)	Sexual health is the ability of women and men to enjoy and express their sexuality and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. In order to be sexually healthy, one must be able to have informed, enjoyable and safe sex, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexually health <i>[sic]</i> experiences enhance life quality and pleasure, personal relationships and communication, and the expression of one's identity.
U.S. Department of Health and Human Services (2001)	Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. Sexual health is not limited to the absence of disease or dysfunction, nor is it important <i>[sic]</i> confined to just the reproductive years. It includes the ability to understand and weight the risks, responsibilities, outcomes and impacts of sexual actions and to the practice abstinence <i>[sic]</i> when appropriate. It includes freedom from sexual abuse and discrimination and the ability to integrate their sexuality into their lives, derive pleasure from it, and to reproduce if they so choose.
The National Strategy for Sexual Health and HIV (2001)	Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life, and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness, or disease.

(table continues)

Source	Definition
Robinson et al. (2002)	Sexual health is an approach to sexuality founded in accurate knowledge, personal awareness and self-acceptance, such that one's behavior, values and emotions are congruent and integrated within a person's wider personality structure and self-definition. Sexual health involves the ability to be intimate with a partner, to communicate explicitly about sexual needs and desires, to be sexually functional (to have desire, become aroused, and obtain sexual fulfillment), to act intentionally and responsibly, and to set appropriate sexual boundaries. Sexual health has a communal aspect, reflecting not only self-acceptance and respect, but also respect and appreciation for individual differences and diversity, as well as a feeling of belonging to and involvement in one's sexual culture(s). Sexual health includes a sense of self-esteem, personal attractiveness and competence, as well as freedom from sexual dysfunction, sexually transmitted diseases, and sexual assault and coercion. Sexual health affirms sexuality as a positive force, enhancing other dimensions of one's life.
World Health Organization (2002)	Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

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may lead to the development of problems in relationships and sexual functioning.

Additional barriers to healthy sexuality may include lack of availability of contraceptives and STI protection, lack of partner cooperation, poor communication between partners, a sense of powerlessness, and lack of acceptance of “the realities of one’s own sexual behavior” (Chilman, 1990, p. 128).

Just as sexuality researchers have failed to settle on a single definition of healthy sexuality, emerging adults do not uniformly agree on the meaning of healthy sexuality. A recent study investigated the different ways that students at a Midwestern university understood the meaning of healthy sexuality (Wagner, 2008). Using Q-sort methodology, 19 students ranging in age from 18-25 evaluated the importance of 56 statements in

characterizing healthy sexuality. Although there was consensus on some aspects of healthy sexuality, three distinct patterns of attitudes about healthy sexuality emerged: Factor A: My Partner and I/ What We 'Should' Be Doing, Factor B: The Freedom to Find Our Own Way/Making it Better for Everyone; and Factor C: Men Will Be Men/It's All About the Sex.

Distinguishing characteristics of Factor A included “more important” sorting of statements regarding abstinence, religious beliefs, and monogamy or commitment to one person and “less important” sorting of statements regarding pleasurable sexual behavior, experimentation and variety, masturbation, and options for terminating pregnancy. Subjects in this factor also “tended to focus on individual responsibility and personal choices” (Wagner, 2008, p. 110). Distinguishing features for Factor B included “more important” ratings of not being or feeling ashamed of one's own sexuality, not feeling judged or guilty; access to resources, sanitation, birth control, condoms, doctors, testing, and services; and acceptance of one's own sexual or gender identity. This factor “most closely aligned with more ideal and positive representations of sexual health that are characteristic of the international definitions” (p. 118). Statements ranked most highly for Factor C pertained to sexual pleasure and a variety of sexual behaviors. All subjects in this factor were male, and themes of competition and social status were observed during interpretation.

Despite these three distinct patterns of responses, consensus was found for many of the sexual attitude statements. Themes that were considered important aspects of healthy sexuality across participants included basic disease prevention, consent and

respect, education, emotions, and health. There was also consensus on statements that did *not* characterize healthy sexuality, including casual sex and sex involving multiple partners, sex motivated by something other than positive feelings or pleasure, rules or restrictions on expression, and negative sexual expression. Wagner (2008) emphasized that subjects in the study had stronger ideas and consensus about what composed *unhealthy* sexuality than healthy sexuality.

Sexual Knowledge

Individual identity exploration during emerging adulthood may include reevaluation of many aspects of sexuality, including sexual orientation, beliefs about abstinence, premarital sex, monogamy, contraception, gender, and sexual behaviors (Lefkowitz & Gillen, 2006; Wagner, 2008). It may be expected that basic sexuality knowledge related to these domains would be well established for individuals beginning college; however, this does not appear to be true for large numbers of college students.

In an examination of college student sexuality knowledge students performed poorly, averaging 55.39% ($SD = 15.59$) correctly answered items (Synovitz, Herbert, Kelley, & Carlson, 2002). Mean scores within the test were 66.4% accuracy on the contraception section, 60.6% on gender, 53.7% on anatomy, and 47.4% on STIs—these scores would barely qualify as passing grades in academic terms. Females scored significantly higher on the knowledge test than males, primarily due to greater accuracy on items in the contraception section. Knowledge accuracy increased with amount of college experience, with seniors outperforming juniors, juniors outperforming sophomores, and freshmen scoring lowest of all. Based on their findings, the researchers

recommend that university campuses “[realize] that not all students take human sexuality courses, [and] provide other opportunity for learning through seminars, residence hall talks, peer education groups, and speakers” (Synovitz et al., 2002, p. 171). In a study comparing the sexuality knowledge of college students with that of adults with mild intellectual disability, scores were comparable in areas relating to knowledge of menstruation and body part identification, and no differences were found with regard to knowledge of sexual abuse, masturbation, and homosexuality (Szollos & McCabe, 1995). Such results were supported recently in a similar study of adults with mild to moderate intellectual disability (Galea, Butler, Iacono, & Leighton, 2004). These individuals averaged 51.9% accuracy overall on a test of sexuality knowledge, rivaling the scores of college students as found by Synovitz and colleagues, and scored higher on sections addressing knowledge of parts of the body (77.6%) than the college students.

The Kaiser Family Foundation regularly examines the knowledge, attitudes and questions that young people in the United States have about sex. Their most recent report (2003) emphasized that “young people are more concerned about sex and sexual health than any other health issues in their lives” (p. 2); however, the survey revealed that young people have many misconceptions about sexuality, particularly with regard to contraception and STI prevention. While nine out of ten considered sex with a condom to be “safer sex,” seven out of ten also considered sex with other forms of birth control to be safer sex even though these methods do not protect against STIs. Twenty percent considered the withdrawal method (“pulling out” of the vagina prior to ejaculation) or sex during a woman’s menstrual cycle safer sex. Although more than 75% said that sex

without a condom was not worth the risk, one in six believed that “sex without a condom is ‘not that big of a deal’ and one in 10 [said] that ‘unless you have a lot of sexual partners you do not need to use condoms” (p. 4). Nearly one-in-five young adults believed that condoms are “not effective” in preventing STI transmission, including transmission of HIV. Twenty percent of young people did not know that STIs could be transmitted through oral sex, and 40% considered oral sex to be “safer sex.” Although 50% of sexually active young people reported that they had been tested for STIs and HIV, 30% held the false belief that these tests are a standard feature of regular medical exams. One fifth believed that they would simply “know” if someone else had an STI even if they were not tested, and one sixth believed that STIs could only be transmitted if obvious symptoms were present.

Although evidence suggests that adolescent and young adult knowledge regarding sexuality is lacking in many fundamental areas, young people do want to know more. The Kaiser Family Foundation report (2003) stated that more than 75% of adolescents and young adults have a desire for more information about sexual health. Specific concerns included recognizing STIs, learning more about what STI testing involves and where they could receive testing services, and a desire for more information about how to use condoms. Forty percent reported that they wanted “more information on how to communicate more effectively with partners about sensitive sexual concerns and issues” (p. 5). In a sample ($n = 55$) of college students asked to describe an “ideal” sexuality education program, 91% reported wanting more information about STIs (including details such as incidence, effects, and consequences) than they received in

their own sexuality education history (von Sadvoszky, Kovar, Brown, & Armbruster, 2006). Sixty-one percent wanted more information about STI prevention, and 47% wanted more information about contraception. Questions and concerns about safer sex practices are also the most common sexual issues raised by clients in therapy sessions (Reissing & DiGiulio, 2010).

Sexual Behavior

It is estimated that 50% of all high school students will have engaged in sexual intercourse by the time they graduate high school (Kotchick, Shaffer, Forehand, & Miller, 2001). For a variety of reasons including lack of education, poor access to contraceptives, and the adolescent belief of “it can’t happen to me,” adolescents are likely to engage in reproductive health risk behaviors such as inconsistent or non-use of condoms and/or other contraceptive methods, having multiple sexual partners, and use of drugs or alcohol prior to or in conjunction with sex (Kotchick et al., 2001). Consequences of these risky behaviors among US young adults include some of the highest rates of sexually transmitted infections and teen pregnancies among industrialized nations (Schalet, 2004).

In the US, young adults ages 15-24 have the highest rates of STIs (Centers for Disease Control and Prevention [CDC], 2005) and account for half of all new STI infections (Weinstock, Berman, & Cates, 2004). The most commonly acquired STI is human papillomavirus (HPV), followed by trichomoniasis and chlamydia with these three STIs accounting for 88% of all new STI cases among young adults (Weinstock et al., 2004). US teens have the highest rates of unintended pregnancy among women (Foster, Biggs, Ralph, Arons, & Brindis, 2008), and those teens who become pregnant are

more likely to have high-risk births, drop out of school, be single parents, and are substantially more likely to live in poverty than their peers who do not experience an unintended pregnancy (Foster et al., 2008). Within this young group, ethnic minority adolescents are twice as likely to become pregnant and give birth than their White peers, and have STI rates that are three to ten times higher (Milan et al., 2006).

Risk of STI transmission and unwanted pregnancy can be dramatically reduced by the use of barrier methods such as condoms and dental dams; however, usage of such devices among adolescents and young adults remains low. In a study of 411 teens (average age 17.3), most participants reported using condoms 50% of the time while 28% reported never using a condom, and 33% reported two or more sexual partners in the past year (Kershaw, Ethier, Niccolai, Lewis, & Ickovics, 2003). The CDC (2006) reported that 40% of sexually active college students did not use a condom during their most recent sexual encounter. However, large numbers of teens and young adults are seeking reproductive health services. Young women cite educational goals and financial concerns as their top reasons for wanting to delay pregnancy (21 and 23%, respectively), as well as feeling too young (10%), not wanting children (10%), relationship reasons (8%) and feeling unready to become a parent (6%; Foster et al., 2008). Beyond initially seeking reproductive health services, consistent and correct use of contraceptives is the primary determinant of their effectiveness (Petersen, Albright, Garrett, & Curtis, 2007).

Sexual coercion, sexual assault, and rape are also important behavioral aspects of emerging adult sexuality to examine. Research demonstrates that sexual coercion is prevalent among young people, especially when it comes to dating partners. In a study of

433 college students (277 female, 156 male), 43% of women and 17% of men reported having had an “unwilling” sexual experience in the past year (O’Sullivan, Byers, & Finkelman, 1998). Most reports of sexual coercion involved verbal pressure from a dating partner, friend or acquaintance, illuminating the role of poor sexual communication in unwanted sexual experiences and the importance of clear communication and respect for sexual boundaries.

Sexual Communication

Sexual communication with one’s partner(s) is emphasized in the majority of definitions of sexual health. Sexual communication refers to the process of discussing one’s sex life with one’s partner, and may include discussion of sexual histories, preferences and limits, and safe-sex practices (Boyle & O’Sullivan, 2010; Greene & Faulkner, 2005; Holmberg & Blair, 2009). A more specific construct within sexual communication that emphasizes willingness and ability to talk about sex and satisfying sexual behavior is known as sexual assertiveness (Greene & Faulkner, 2005). Sexual assertiveness may include the ability to initiate or refuse sexual activity, negotiate which sexual behaviors to engage in, and address safe-sex practices and contraceptive use (Morokoff et al., 1997).

E. Sandra Byers, who has researched sexual communication for over 30 years, stated in a recent summary (2011) of her program of research that findings have consistently demonstrated “that sexual communication is important to sexual satisfaction and sexual well-being” and that “individuals who self-disclose more about their sexual likes and dislikes to their partner report greater sexual well-being” (p. 22). Self-disclosure

and sexual satisfaction are linked through two pathways, an instrumental pathway and an expressive pathway (MacNeil & Byers, 2009). The instrumental pathway is “based on the assumption that disclosure of sexual likes and dislikes is a way of informing and obtaining more of what one likes and less of what one does not like sexually” while the expressive pathway “posits that sexual and nonsexual self-disclosure leads to higher sexual well-being by enhancing intimacy that in turn enhances sexual well-being” (p.22) (Byers, 2011). MacNeil and Byers’ line of research has demonstrated clear support for both pathways in men and women in both short- and long-term relationships.

However, Byers’ research has also shown that despite the positive outcomes of sexual communication, it is not happening as frequently in intimate relationships as one might assume. In a study of 104 couples in long-term relationships (range: 2y-45y, mean = 14y), individuals rated their self-disclosure of sexual likes and dislikes on a 7-point scale ranging from having told their partner *nothing at all* to *everything* (MacNeil & Byers, 2009). Both women’s and men’s self-evaluations fell in the middle of the scale (Women: $M = 4.9$, $SD = 1.4$; Men: $M = 4.6$, $SD = 1.5$), “indicating that even after being in a relationship for 14 years, partners had not told their partner everything about their sexual preferences” (p. 22, Byers, 2011).

Prior research suggests a small but significant tendency for heterosexual women to score more highly on constructs of sexual communication and assertiveness than heterosexual men (Byers & Demmons, 1999; Catania, 1998; Greene & Faulkner, 2005), although a more recent study investigating sexual communication in same-sex and mixed-sex relationships found no significant differences among lesbians, gay men,

heterosexual women and heterosexual men (Holmberg & Blair, 2009). In an examination of partner communication in heterosexual relationships, about half (53.7%, 29/54) of participants reported that they could “talk about sex in a very direct and detailed verbal fashion with their partners,” while a minority of participants relied on nonverbal communication (5.5%, 3/54), partners “just knowing” what they liked (7.4%, 4/54), or a balance of direct and indirect communication (14.8%, 8/54; Boyle & O’Sullivan, 2010). In the same study, about a third of participants reported sexual topics were discussed easily and often (35.2%, 19/54), while slightly less reported this was a difficult topic or could only be discussed “under particular circumstances” (29.6%, 16/54) and others reported that they avoided the topic altogether or it “just doesn’t come up.” Additional reasons that individuals may not engage in sexual communication include fear of a partner’s negative reaction, embarrassment or discomfort, shyness, fear of “ruining the moment,” and things happening too fast (Oattes & Offman, 2007).

Gender-role beliefs and stereotypes may also influence sexual communication. In one study of 52 heterosexual couples, perceptions of partners’ ideals regarding foreplay and intercourse were more strongly related to one’s own stereotypes of “what women/men want” than to their partner’s actual reported preferences (Miller & Byers, 2004). This “suggests that people use stereotypes to guide their understanding of their partner’s preferences more than they use explicit or implicit information communicated by their partner” (Byers, 2011, p. 22). Couples with less traditional beliefs about gender roles and sexuality (e.g., egalitarian roles) report greater communication about sexual issues than those with more traditional attitudes (e.g., belief that men are initiators of sex

while women are protectors of chastity; Greene & Faulkner, 2005).

But how is the skill of sexual communication acquired? Chilman (1990) suggested the development of communication skills through interaction with peers of both sexes, including discussion and exercises regarding topics such as values, feelings, goals, and wishes about relationships and sexual behaviors, understanding female and male sexual response, and safe sex practices (protection from STIs and unwanted pregnancies). Such education may serve as a corrective experience to the vast array of mixed messages adolescents and young adults receive about sexuality from sources including media and pornography. Other researchers have proposed emphasizing models that integrate mixed-sex discussion groups, which may enhance self-efficacy in communication about sexual topics by building social skills and additional knowledge (Wight & Abraham, 2000).

Sexual Self-Esteem and Sexual Self-Efficacy

Self-esteem and self-efficacy are significant factors in discussing sexual health. Self-esteem or self-worth is integral to sexual health because people must have some level of self-respect in order to develop the confidence to make independent, healthy decisions about the actions and behaviors in which they elect to engage (Tayside Region Education Department, 1993). Individuals with higher levels of self-esteem experience more ease in self-control and reduced anxiety and guilt about not living up to self- or other-imposed standards of behavior (e.g., total abstinence from sexual behavior; Chilman, 1990). While self-esteem is often examined at a global level, more specific levels within the construct often demonstrate greater predictive value than the global

construct (Coopersmith, 1967; Dutton & Brown, 1997; Oattes & Offman, 2007; Rosenfeld, 2004; Zeanah & Schwarz, 1996). Sexual self-esteem is defined as “affective reactions to subjective appraisals of sexual thoughts, feelings, and behaviours” (Zeanah & Schwarz, 1996, p. 3) and is considered a contributing factor to global self-esteem. Sexual self-esteem has been positively linked to sexual communication including partnered discussions of STIs and sexual history while global self-esteem appears to be too broad a construct to relate (Oattes & Offman, 2007; Rosenfeld, 2004).

Self-efficacy, including perceived behavioral control and motivation, is also important: individuals need to have a sense of capability as well as knowledge (Meaney, Rye, Wood, & Solovieva, 2009). Higher levels of sexual self-efficacy are predictive of positive attitudes regarding contraception and engagement in safe sex (Weiser & Miller, 2010). Sexually self-efficacious individuals also experience a greater sense of control in sexual experiences, including advocacy for one’s sexual interests, lower levels of sexual anxiety, and higher levels of sexual self-awareness and sexual-subjectivity (Horne & Zimmer-Gembeck, 2005). Sexual subjectivity has been defined as the ability to feel confident in and in control of one’s body and sexuality (Thompson, 1990) and may be contrasted with the concept of sexual objectification—that is, experiencing one’s body exclusively as an object for the pleasure of others. For young women, internalized conventional ideas about femininity and self-objectification appear to reduce feelings of sexual self-efficacy (Tolman, Impett, Tracy, & Michael, 2006). Those without adequate knowledge and self-acceptance may have difficulty discerning choice from coercion (Thompson, 1990).

Sexual self-efficacy may also be tied to sexual empowerment. Psychological empowerment has been defined as a feeling of control over one's life (Rissel, 1994), and has been divided into three subcomponents, each of which may be used to understand the concept of sexual empowerment (Zimmerman, 1995). Intrapersonal components include perceived control, competence, and mastery (e.g., feelings of sexual self-efficacy, desire, and pleasure; Peterson, 2010). Interactional components include awareness of options, resources, and problem-solving and decision-making skills (e.g., knowledge of pleasure, clear desires, and communication with a sexual partner; Peterson, 2010). Behavioral components include taking actions to directly influence outcomes (e.g., asking for what one wants, refusing unwanted experiences, and general sexual exploration, alone or with a partner; Peterson, 2010). It is likely that greater experience of empowerment in any and all of these dimensions would significantly contribute to positive sexual experiences, and therefore improved sexual health.

Sexuality Education

A common theme across many definitions of sexual health is the need for accurate knowledge regarding sexual development and functioning, as well as understanding one's own values and beliefs about sex and human sexuality. Adolescents surveyed in the Kaiser Family Foundation report (2003) indicated that their top three sources of information were sex education in schools, friends, and parents, closely followed by media sources such as television, movies, magazines and the Internet. Young adults in the study did not emphasize sex education, but "stress[ed] the importance of

friends, the media, and boyfriends and girlfriends as their most important sources of information” (p. 5). Other features of sexuality education include learning about the opposite sex, the sexual behaviors of others, and that sex is a part of life (Schiller, 1973). Despite this, many sexuality education programs don’t venture beyond providing information about risk prevention (i.e., often inaccurate information regarding contraception and STI prevention measures), with little or no conversation about personal values and beliefs beyond promoting abstinence-only perspectives. Sexuality education at the familial level and in public education will each be examined below, as well as recommendations for sex education programs.

Familial Influence

Family communication is the primary source of information regarding sex related issues for adolescents (Sexuality Information and Education Council of the United States, 1999). Within the immediate family, mothers are more likely to discuss sex with their daughters (Chilman, 1990). However, the majority of mothers reported feeling “uncomfortable” talking to their daughters and 45% of female adolescents reported feeling “somewhat” or “very” uncomfortable talking with parents about sexual topics (Fox & Inazu, 1980; Hutchinson & Cooney, 1998). Fathers are less likely to discuss sexual topics with any of their children in comparison to mothers (Chilman, 1990). However, the vast majority of young women (87%, Hutchinson & Cooney, 1998) reported that they would have liked more information from their fathers. Young men are least likely to experience parental communication about their sexuality, with about one third of adolescent boys receiving at least “some” information compared to almost half of

adolescent girls (Chilman, 1990; Hutchinson & Cooney, 1998).

In an interesting examination of cultural attitudes, Schalet (2004) published a sociological comparison of United States parent attitudes regarding sexual behavior with the attitudes of parents in the Netherlands based on a series of interviews with parents ($n = 58$) and teenagers ($n = 72$) in the two countries. The US and the Netherlands are similar in terms of wealth, education, and reproductive technologies. However, the picture of teen sexuality is very different across countries, with the highest and lowest rates of teen pregnancy (respectively) in the Western world. In both countries the white, moderately religious or secular middle class holds the dominant influence on healthcare, education, politics, and media. Schalet examined parent attitudes about teen sexuality and noted some striking differences, which she described as dramatization versus normalization. When parents were asked if they would allow their child to spend the night with a girlfriend or boyfriend in his or her room at home, 9/10 US parents said not until their child was out of high school while 9/10 Dutch parents said either yes or that they would at least consider it at the age of 16-17. US parents listed concerns about “raging hormones out of control,” a “battle between the sexes” (meaning different stakes and purposes for male versus female sexuality), and a “not under my roof” mentality, with one parent stating that she would prefer her children keep secrets than let her know what they are up to sexually. Dutch parents, on the other hand, reported that they believed their children had sufficient self-control to sleep with their partner without engaging in sex, their children would engage in relationship-based sex at appropriate times, and sexuality was something “normal” that should be discussed openly and not kept secret. The social

(and familial) stigma in the US regarding adolescent sexuality is likely a barrier for many young people in asking for advice or seeking reproductive health services when they are considering sexual activity.

In a study of religious influences on parent-child communication about sexuality, Regnerus (2005) suggested that parents may be more likely to shape their children's attitudes about sex rather than their knowledge. In an examination of data from the first wave of the National Longitudinal Study of Adolescent Health and the National Study of Youth and Religion, the author concluded that many conversations about sex and contraception appear to be motivated by the perceived risk to the teen. Regnerus' noted that 85% of parents reported that they had talked with their daughter about sex, while only 50% reported having a similar conversation with sons. Parents were more likely to discuss the emotional impact of sex, loss of respect, immorality, and virtues of virginity with their daughters. When the influence of religiosity was considered in terms of parental communication, it appeared that frequent church attendees were more likely than less frequent attendees to talk "a great deal" about the moral issues of sex with their children (47% and 32%, respectively). However, the more frequently parents attended religious services the less likely they were to communicate with their children about sex and birth control.

Due to the significantly high proportion of members of The Church of Jesus Christ of Latter-day Saints (LDS or Mormon) in the area in which the present study was conducted, special attention is paid to LDS attitudes about sex and contraception here. With regard to familial communication, research indicates that LDS parents demonstrate

high rates of communication with their children about sex (0% reported never talking about sex; Regnerus, 2005); however, this communication is narrowly focused on the importance of abstaining from sex outside of marriage. When compared to other religious denominations, LDS individuals are less likely to approve of premarital sex (Holman & Harding, 1996). When polled, 74% of LDS reported disapproval of sex outside of marriage, as compared to 47.3% of Catholics, 36.8% of Jews, 55.2% of Conservative Protestants, and 24.4% of those with no religious affiliation. These beliefs appear to be strong and long-standing among the followers of the LDS faith.

Despite the fact that 100% of LDS parents in the Regnerus (2005) study reported communication with their children about sex, LDS members were more likely to avoid conversations about birth control than most other religious groups (Regnerus, 2005). Historical leaders of the LDS church have issued strong statements indicating disapproval of contraceptive methods; however, attitudes among LDS members regarding contraception have not been as strict. As early as 1935, polls of young women at Brigham Young University (an LDS educational institution) indicated that 89% “believed in” birth control (Proctor, 2003). In 1967 a poll of University of Utah LDS female students indicated that 93% of women intended to plan or space their children, and follow-up studies indicated that 90% of University of Utah LDS students approved of the use of contraceptives (Hastings, Reynolds, & Canning, 1972). Differences in the approval rate between Mormon and non-Mormon students were minimal.

Contraceptive use rates among LDS couples do appear to differ from those among members of other religious groups. LDS families report a lower proportion of

contraceptive pill use compared to others (19% of LDS compared to 27% of Mainline Protestants, 31% of Fundamentalist Protestants) and higher rates of condom use (19% of LDS compared to 13% among Fundamental Protestants and Other; Goldscheider & Mosher, 1991). LDS families tend to utilize greater proportions of male contraceptive methods (i.e., condoms and male sterilization) than other religious groups as well as lower rates of female contraceptive methods (primarily the contraceptive pill).

Public Education

Formal instruction about sexual health has changed significantly in the US over the past two decades. Of adolescents aged 15-19, 81% of males and 87% of females received information about birth control in 1995, while only 66% of males and 70% of females received similar information in 2002 (Lindberg et al., 2006). One of the most significant changes to sexuality education during this period has been federal financial support for abstinence-focused programs. Landry and colleagues (1999) found that 69% of public schools are involved in district-wide sexuality education. Within these programs, 14% treat abstinence as “an option” for adolescents, 51% teach abstinence as “the preferred option” but permit discussion about contraception (i.e., “an abstinence-plus” policy), and 35% teach abstinence only, “with discussion of contraception prohibited or limited to discussion of its lack of effectiveness” (Landry et al., 1999). Despite broad public support for the encouragement of abstinence in the United States, the majority of US citizens believe sexually active youth should have access to contraception (Landry et al., 1999; Kaiser Family Foundation, 2004).

Historically,¹ the US government has spent more than \$200 million annually on abstinence-only sexuality education (AOSE) programs (Rosenbaum, 2009). More than 90% of this funding did not require that curricula be scientifically accurate, and it has been demonstrated that 11 out of 13 federally approved programs contained incorrect information, particularly regarding the effectiveness of contraceptive methods and STI protection. These programs often incorporate the goal of producing “virginity pledgers.” However, research suggests that within one year 50% of pledgers deny having pledged and at 5 years, 82% deny having pledged (Rosenbaum, 2006). When matched with non-pledgers for comparison, no differences are found in rates of premarital sex or sexually transmitted infections. However, pledgers are significantly less likely to use birth control or condoms when sexually active, and demonstrate lower self-efficacy and knowledge regarding contraception. These adolescents are also more likely to engage in non-vaginal forms of sex including oral and anal sex, topics that are not covered in abstinence-only models, and are less likely to use protection during these forms of sex (Kempner, 2001, as cited in Weiser & Miller, 2010).

Another significant concern with regard to abstinence-only sexuality education policies is the exclusion of discussions relevant to lesbian, gay, bisexual, transgender, and queer (LGBTQ) teens (Kempner, 2001, as cited in Weiser & Miller, 2010). Abstinence-only programs advocate for refraining from any form of sexual contact outside of legally and religiously sanctioned heterosexual marriage, thereby neglecting to so much as

¹ Although recent policies under the Obama administration have reduced funding for ASOE programs in favor of more comprehensive sexuality education, many schools continue to utilize these programs.

acknowledge the presence of LGBTQ students let alone the sexual experiences that may be a part of these student's lives. Such programs have been criticized by many legal, policy, and advocacy groups such as Lambda Legal, the American Civil Liberties Union, and the Society for Adolescent Medicine due to their inherent discrimination against LGBTQ youth and contribution to dangerous environments for these individuals (C. M. Fisher, 2009), and have been described as "unethical, uncaring, and undemocratic, not to mention out of touch with the realities of lives of youth no matter what their sexualities" (Elia & Eliason, 2010, p. 28). These programs may contribute to "active silence" (avoidance) regarding discussion of sexual orientation, provide misinformation about the risks associated with same sex sexual behavior (e.g., exaggerated HIV and other STD rates), and deny LGBTQ students "a socially sanctioned safe space for the expression of same-sex feelings and desires" (C. M. Fisher, 2009, p. 63). LGBTQ identified and questioning youth may report feeling excluded, out of place, and as though they do not "matter" in these classrooms, leading to increased feelings of isolation, internalized homophobia, suicidal ideation and behavior, and, in hindsight, anger (C. M. Fisher, 2009). Refusal to acknowledge the existence of LGBTQ students perpetuates homophobia among straight and LGBTQ students by neglecting opportunities to teach tolerance and acceptance (Rienzo, Button, Sheu, & Li, 2006). Additionally, denial of the normalcy of adolescent sexual exploration is potentially harmful to all students, and particularly damaging to LGBTQ individuals (Elia & Eliason, 2010). As abstinence-only education continues to be debated and criticized for its degree of efficacy, the impact of these policies on LGBTQ youth remains absent from many of these conversations.

Following a review of school-based sexuality education policies, Weaver, Smith and Kippax (2005) concluded that “pragmatic and sex positive government policies” (p. 171) such as those held in France, Australia, and the Netherlands have significantly better outcomes than the morally based abstinence-emphasized policies supported in the United States (outcomes include rates of teen pregnancy and abortion, use of contraception, and STI prevalence). In contrast to the morally driven policies that have been prevalent throughout recent decades in the US, sexuality education programs in the Netherlands are intended to non-judgmentally provide youth with the ability to identify safe and unsafe sexual practices as well as knowledge about responsible sexual behavior should they elect to have sex (Weaver et al., 2005). Despite common misconceptions that such pragmatic policies “promote” sexual activity, the average age of sexual debut is not significantly different in countries that have established “liberal” sex-education programs compared to the United States. Based on such findings, it appears that abstinence-only education programs place young adults in the United States at a significant disadvantage, in large part due to their prevention of the development of a “safe sexual culture” for young people (e.g., development of sexual negotiation skills, encouraging informed and responsible sexual activity; Weaver et al., 2005).

With the apparent change in the content and focus of sexuality education in schools, questions have been raised as to where young people find information on sexual health. In 2000, one study of 412 10th graders indicated that the Internet was the most common source of information regarding sex and birth control, though the participants indicated that they valued information from friends and parents more highly

(Borzekowski & Rickert, 2001). More recently, Jones and Biddlecom (2011) interviewed 58 high school juniors and seniors recruited from three sites (one large and one small high school in New York City, and one large high school in Indiana) regarding their usage of the Internet for sexual information. Results indicated that only a minority of participants reported finding contraceptive information online, and many of those who did only searched for information due to school assignments or to “double check” something they had learned from another source. Many participants indicated that they “knew the information was there if they needed it” but were not “motivated” to look it up. Of note, almost all participants reported involuntary exposure to sexually explicit photos or pictures or advertisements for pornography. Although the study indicated that the Internet is not currently “filling the gap” in sexual health education, the authors suggested that parents and educators increase their own knowledge about online resources (e.g., sexetc.org, iwannaknow.org, and scarleteen.com).

Based on the demonstrated ineffectiveness (and potential harmfulness) of abstinence-only sexuality education, comprehensive sexuality education appears to be a positive alternative. Comprehensive education provides adolescents with accurate information about contraception, STIs and pregnancy, and real consequences of sex (Weiser & Miller, 2010). It has also demonstrated success in delaying the initiation of sex, reducing the number of sexual partners, and increasing use of contraception and condoms (Kirby, 2007; Schwarz, 2007; WHO, 2004). Research indicates that the most effective sexuality education programs teach methods for reducing sexual risk, addressing social pressure, reinforcing individual values, and fostering confidence in

one's ability to engage in responsible sex (Kirby et al., 1994). Because there are fewer moral agendas (e.g., religious influences, homophobic/heteronormative values) present in comprehensive sexuality education, these programs are more likely to address the needs of all adolescents, including LGBTQ teens.

Despite the evidence that many young people's school-based sexuality education experiences tend to be incomplete at best, college-level sexuality education is almost never a graduation requirement. When such courses are offered, this tends to be only through upper-level courses in specific disciplines, restricting broader student access to formal sexuality education (Smith, Menn, Dorsett, & Hugill-Warren, 2012). Due to this limitation, many college students' best chance at receiving further information about sexual health may be through programming offered by their university. A handful of college-level interventions have been designed, typically targeting topics such as HIV/STI prevention, pregnancy prevention, or reducing rates of sexual assault. Few programs seem to address the breadth of healthy sexuality as described above, though there are some that offer more "open-ended" programs which invite participants to shape the content of intervention through facilitating dialogue or soliciting student questions to be addressed in the presentation (Moore, Smith, & Folsom, 2012; O'Grady, Wilson, & Harman, 2009; Smith et al., 2012). Published material on such interventions tends to focus on the rationale behind these interventions, program design and implementation, and participant feedback. Formal evaluation of the impact of these interventions on constructs such as knowledge, attitudes, and behaviors appears to be severely limited (Smith et al., 2012).

Recommendations for Sexuality Education

A number of researchers and organizations have offered suggestions for improving sexuality education for adolescents and young adults in the United States and elsewhere. For instance, the American Academy of Pediatrics has issued multiple guidelines for pediatricians in providing sexuality education to children and adolescents, although few of these suggestions are exclusively applicable to medical professionals. Relevant proposals include: promoting communication in relationships and between partners; acknowledging that sexual activity may be pleasurable but must be engaged in responsibly; “ensur[ing] that adolescents have opportunities to practice social skills, assertiveness, control, and rejection of unwanted sexual advances” (American Academy of Pediatrics, 2001, p. 500); providing handouts to reinforce safe-sex practices and decision-making; maintaining nonjudgmental attitudes; and avoiding heterosexual bias. Suggestions from other sources include: providing a list of comprehensive sexual health websites for later reference (Jones & Biddlecom, 2011), basing interventions on what young people look for regarding sexual health information and resources (Oakley et al., 1994), facilitating mixed-sex discussion groups to enhance social skills relevant to sex-related communication (Wight & Abraham, 2000), and fostering sex positive environments for young people to learn in (Weaver et al., 2005).

Theoretical Framework

In 1992, J. D. Fisher and Fisher proposed the Information-Motivation-Behavioral skills (IMB) model, which was “originally developed to provide an account of the

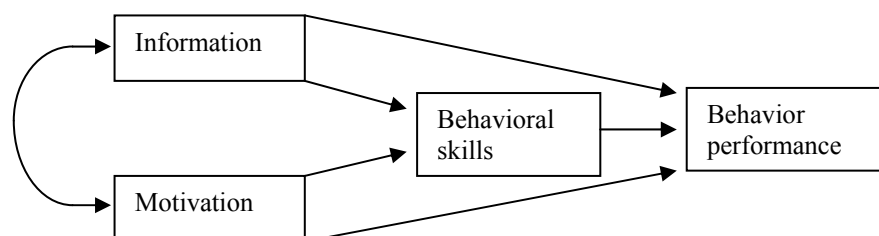
psychological determinants of HIV risk and preventative behavior” (W. A. Fisher, Fisher, & Harman, 2003, p. 83). Unlike many other models of health behavior change, which examine information, motivation, and behavioral skills independently, the IMB model focuses on these three factors comprehensively. First, the impact of these three components on health promoting behaviors will be described. Next, the framework for designing and evaluating an IMB based intervention will be outlined. Finally, empirical support for use of the IMB model in health promotion interventions will be briefly summarized.

Within the IMB framework, information is considered an initial prerequisite of behavior change. Health information includes specific facts, relevant heuristics (or cognitive short-cuts), and more elaborate implicit theories that impact health-based decision making processes (W. A. Fisher et al., 2003). For example, an individual’s decision to engage in safer sex practices with a given partner may be influenced by factual knowledge (e.g., “Condoms reduce risk of STI transmission”), heuristics (e.g., “Monogamous sex is safe sex”), and implicit theories (e.g., “Familiar and trusted people who dress and act in predictable ways are safe partners”). Based on this framework, addressing information in health promotion interventions should involve not only increasing factual knowledge (e.g., facts about infection transmission) but also correcting myths and misconceptions that influence heuristics and theories (e.g., that one could determine how “sexually risky” a partner is based on superficial information like appearance or that they are from a small town; J. D. Fisher & Fisher, 1992; O’Grady et al., 2009).

Motivation is another important influence which may impact whether even well-informed individuals will be inclined to engage in health promoting behaviors (W. A. Fisher et al., 2003). This influence exists at two levels: the personal and the social. Personal motivation refers to an individual's own attitudes toward engaging in a behavior (e.g., safer sex practices). Social motivation refers to perceived social support for engaging in such behaviors (e.g., peer attitudes and social norms regarding sexual behavior). The influence of social motivation on performance of health promoting activities has been demonstrated with regard to multiple behaviors, including condom use, breast self-examination, and adherence to medical regimens (W. A. Fisher et al., 2003).

In addition to information and motivation, individuals must also develop the behavioral skills to effectively engage in health promoting behaviors. Behavioral skills include objective skills for performing behaviors and the self-efficacy for doing so. For example, in enacting safer sex practices with a partner one must have both knowledge and self-efficacy regarding ways to acquire and properly use protective methods (e.g., contraception, condoms, dental dams), how to communicate values and/or intended behaviors regarding safer sex, and the use of these practices over time.

In summary, the Information-Motivation-Behavioral Skills model examines the relationships between these three constructs with the assumption that the effects of information and motivation are seen through the application of skills in initiating and maintaining health promoting behaviors. The relationships among these constructs are presented in Figure 1. According to the model, information and motivation influence one



From J. D. Fisher & W. A. Fisher (1992). Changing AIDS risk behavior. *Psychological Bulletin*, 111, 455-74. Copyright by APA. Reprinted with permission.

Figure 1. The information-motivation-behavioral skills model of health behavior.

another, but are not necessarily correlated (e.g., someone with a great deal of information may not be motivated and vice versa). Both of these constructs in turn influence behavioral skill, and all three constructs influence the actual performance of behaviors in question. The model is considered highly generalizable with regard to health promotion behaviors, and should be applied with careful consideration of cultural and individual differences among populations investigated (W. A. Fisher et al., 2003).

The developers of the IMB model have outlined important components of developing and evaluating an IMB-informed intervention (W. A. Fisher et al., 2003). The process begins with the conduct of *elicitation research* with a representative subsample of the target population. The purpose of this step is to empirically identify levels of information, motivation, and behavioral skills among the target population prior to intervention. This includes assets and deficits in information and motivation, as well as levels of positive and risky behaviors engaged in by the sample. The developers advocate for the use of open- and closed-ended techniques in elicitation research, such as focus groups and questionnaires. The second step involves the design and implementation of

the intervention, which should be “conceptually based, empirically targeted, [and] population specific” (W. A. Fisher et al., 2003; p. 87). This should be designed based on the findings of the elicitation research conducted to address identified deficits and capitalize on existing assets observed within the target population. Finally, outcomes of the intervention should be examined to determine effects in the domains of information, motivation, behavioral skill, and behavior performance. The present project exacted each of these three steps as described in greater detail in the following chapter.

As outlined by W. A. Fisher and colleagues (2003), the IMB model is well supported empirically. Structural equation modeling has supported the model presented in Figure 1, such that information and motivation are unique constructs that are each related to behavioral skills, which is in turn tied to behavior performance. In a review of correlational literature applying the IMB model across several areas of health behavior, information was found to be correlated with performance in 76% of studies (19/25), motivation correlated with performance in 89% of studies (41/46), and behavioral skills correlated with performance in 90% of studies (37/41; W. A. Fisher et al., 2003). The authors concluded “our review of the correlational literature was highly consistent with the IMB model’s assertion that information, motivation, and behavioral skills are fundamental determinants of health behaviors across broad domains of such behavior” (p. 92).

The IMB approach has been applied in multiple studies examining various behaviors and populations (W. A. Fisher et al., 2003). Of most relevance to this project, the IMB model has been useful in predicting college student sexual behavior (J. D.

Fisher, Fisher, Williams & Malloy, 1994) and interventions based on this model have demonstrated effectiveness in increasing HIV/STI preventive knowledge, motivation, behavioral skills, and behavioral engagement (J. D. Fisher, Fisher, Misovich, Kimble, & Malloy, 1996; Jaworski & Carey, 2001; Singh, 2003). In one example, an IMB model-based experimental intervention was designed for use with samples of (primarily heterosexual) college students (J. D. Fisher et al., 1996). Elicitation research was conducted to assess “HIV prevention information deficits, motivational obstacles, and behavioral skills limitations” (p. 91) related to HIV risk behaviors in the sample. Based on the findings of this initial research, an intervention was designed and conducted to address these targets. The intervention was delivered by health and peer educators in male and female dorms and incorporated a number of interactive strategies including videos, discussions, and role play. Outcome research demonstrated significant impact on knowledge, motivation, and behavioral skills 4-weeks following the intervention. In a similar study conducted with inner-city high school students, significant, sustained effects were demonstrated at 1-month and 1-year follow ups (J. D. Fisher, Fisher, Misovich, & Bryan, 2002).

It is important to note that skill-based programs are consistently found to be more effective at changing behavior than knowledge-based programs (Kirby, Laris, & Roller, 2006). As conceptualized in the IMB model, only information that is easily translated into behavior in the social environment is expected to be related to performance of health promoting behaviors. Developers of the model maintain that information is an important foundational component to health behavior performance in combination with the other

factors of the model (motivation, behavior skills). In a review of health based interventions, however, many interventions contained only informational content with motivational factors and behavioral skill components present far less often (W. A. Fisher et al., 2003). Additionally, very few interventions were based on formal elicitation research to tailor interventions to the characteristics and needs of the target population (12%; 7/59). Interventions which incorporated all three components of the IMB model were found to be more effective than those that did not.

Although the present group has a significant focus on increasing knowledge and correcting myths and misconceptions, it is also conceptualized that the discussion-based format facilitates the development of communication skills. Much of the didactic information presented was intended to serve a dual function as both facts to be learned *and* as conversation starter for each session (e.g., anatomy, human sexual response, facts about STIs and contraception). Through discussing this information as a group, participants increased their exposure to sexual vocabulary, communication with others about sexual topics, and self-disclosure regarding values and beliefs. This process was intended to increase self-efficacy in communication about sexuality. Generalization of these new skills to other settings was encouraged during the discussions through identification of occasions, reasons, and ways to initiate and engage in conversations regarding sexuality outside of the group (e.g., with friends, families, and partners).

Summary and Research Questions

This intervention combines principles from the IMB model with conventional

wisdom regarding social skills interventions. By enhancing sexuality knowledge through providing information, enhancing motivation through exploring attitudes, and enhancing self-efficacy for behavioral skills through teaching, discussion, and role-play it was hypothesized that aspects of healthy sexuality would increase among participants, including more positive attitudes about human sexuality, a greater understanding of one's own desires, boundaries, and values, and a greater sense of confidence in one's ability to create and/or shape her/his desired experiences.

The goals of the present study included gaining an understanding of college students' sexuality education histories, their knowledge and attitudes about human sexuality, and their current sexual behaviors. Furthermore, we were interested to see what changes occurred with regard to knowledge, attitudes, and behaviors as a result of participation in the group that has been designed. Specific research questions were as follows:

1. What is the sexuality education history of typical college students?
 - a. Who are their primary sources of sexual information? Who are their preferred sources?
 - b. What have been their parents' and peers' attitudes regarding sexuality?
 - c. How do they describe their school-based sexuality education experiences?
2. What sexual knowledge, attitudes, and experiences are characteristic of college students?
 - a. What level of basic sexual knowledge do college students have? How accurate is this knowledge?

- b. What attitudes do college students hold regarding human sexuality?
 - c. What sexual behaviors are college students engaging in (e.g. frequency of partnered sexual activities, communication with partners regarding sexual matters)?
3. What are the effects of and reactions to the designed intervention?
 - a. Are there changes in the domains of knowledge, attitudes, or behavior as a result of the intervention?
 - b. How do participants' evaluations of this intervention compare to their evaluations of prior sexuality education experiences?

CHAPTER III

METHODS

Program Development

The present curriculum was developed iteratively, beginning with a more extensive, eight-session group outline, followed by a condensed two-session workshop which was delivered as a pilot program, and finally revised into the four-session format present here. Revisions were based on committee feedback, suggestions from other service providers (e.g., USU SAAVI Office), and participant feedback.

Curriculum for the group was developed using a variety of academic and lay resources. These included textbooks commonly used in college-level human sexuality courses (Blonna & Levitan, 2006; Kelly, 2006) as well as resources targeted at less-academic audiences (Corinna, 2007; Friedman, 2011; Valenti, 2010). The curriculum follows a similar format to these educational materials, which typically begin with basic introduction including rationale for improving sexual health and sexual knowledge, followed by foundational information regarding sexual physiology (e.g., anatomy and sexual response). This material is gradually expanded upon to include information about partnered sexual activity, including relational considerations (e.g., communication), health concerns (e.g., information on STIs and pregnancy, safer sex practices), and problematic sexual behaviors (e.g., coercion and assault). Cultural considerations (e.g., familial influence, peer influence, media influence, sexual diversity) are often addressed as a separate topic in texts and curricula, though these were intentionally integrated

throughout the present curriculum as much as possible and were addressed in relation to each topic addressed in the intervention.

The first draft of the curriculum proposed a group that was more therapeutically process-based and incorporated more time specifically intended for participant discussion of personal attitudes and values. In addition to the four topics retained in the final curriculum (anatomy and sexual response; communication; safer sex practices; and preventing unwanted experiences), sessions in the first draft included an entire period devoted to exploration of familial, peer, and personal values; integration of values with other material from group; an open session to address a topic to be determined by the group members (e.g., diversity in sexual orientation, diversity in gender identities and expressions, body image, sexual dysfunctions and their treatments, community education); and group termination. It was determined that a group of this length would pose a significant barrier to recruitment and retention of research participants, and was unfeasible to run as a pilot program.

The program was reduced to two two-hour workshop sessions which were offered through USU Counseling and Psychological Services (CAPS) during the spring of 2011. The first session addressed anatomy, sexual response, and safer sex practices while the second session targeted communication and prevention of unwanted experiences. Each workshop included eight participants, and was led by a female and male coleader pair. Overall, the workshops were well received as evidenced by attendance (greater than most workshops offered by CAPS), engagement, and participant feedback. Anonymous written feedback was solicited at the end of each session, and was used to determine which

aspects of the program to retain, eliminate, or modify. Participant feedback highlighted appreciation for handouts provided, “uncomfortable” ice-breaker activities, and discussion. Participant suggestions for improvement included better management of “people who talked too much,” eliciting greater “respect for the people talking,” and incorporating greater diversity among participants to increase “insights and perspectives” represented in the group.

Based on observations from the pilot workshops and committee feedback, the curriculum was revised into the four session structure examined presently. The four session group was conceptualized to retain the most salient topics with adequate time for discussion. Furthermore, the four session group refocused on the psychoeducational goals of the project, eliminating extra sessions which were more therapeutic (process-based) in nature. Only one significant revision was made to the curriculum following implementation of the groups. Originally, the second half of session four was intended to be used for follow-up survey completion. Based on participant request, this time was reallocated for extended discussion (of previously addressed or novel topics) and participants completed follow-up surveys outside of group.

Recruitment Procedures and Participant Characteristics

The accessible population for this study consisted of Utah State University students. Groups were open to participants aged 18 and older of any sexual orientation, gender identity, racial/ethnic group, religious affiliation, and relationship status. Participants were recruited in a number of ways, including advertisements on campus

(e.g., posters, USU Statesman, course announcements), as well as referrals from multiple offices on campus (e.g., CAPS, SAAVI, Student Health and Wellness Center, and LGBTQ Services).

Over 100 individuals contacted the primary investigator by email or phone for more information about the project ($N = 106$). Brief group-screen meetings were conducted in the researcher's private office with 78 of these individuals (many individuals failed to follow through after initially contacting the researcher by email or phone, and some had questions about the project but were not interested in participating). These meetings served to inform potential participants of the purposes, structure, and primary rules of the group (e.g., confidentiality, respect, commitment to attendance), and gave individuals the opportunity to ask questions that they had about the group. Interested individuals who had no prior relationship experience, a significant history of sexual trauma, or had taken a college level course in human sexuality were excluded. Individual fit was considered based on these criteria, and those whose needs may have been better served by other resources on campus were provided with appropriate referrals ($n = 4$). In most cases, the researcher and individuals were in agreement that the person was a good fit for the group, and the informed consent document was presented (see Appendix B), discussed, and signed ($n = 74$). Seventeen individuals who signed informed consent documents were unable to participate due to scheduling conflicts, although seven of these did complete pretest measures. Therefore, the total sample size for pretest was 63, while the posttest sample size was 56.

As participants were approved through the group-screen process, their names

were added to one of two waitlists. A short-term waitlist was generated as the 8-10 members for the group were recruited. Once the group was established, members were contacted with further information about meeting times and locations. The second, longer-term waitlist was “matched” to the short-term waitlist as much as possible in terms of demographic data (particularly gender). These participants completed pretesting at the same time as the first intervention group, and again two weeks later in order to function as the intervention’s waitlist-control group. Of the 58 group participants, 31 were assigned to the “no wait” condition, and 27 were assigned to the waitlist control. Two participants dropped out in the first week of their assigned group and did not complete posttest assessments. See Table 2 for a timeline of data completion for matched intervention and waitlist groups. Multiple matched intervention and waitlist groups were recruited simultaneously until the proposed sample size was attained.

Table 3 provides descriptive information about the full sample of 63 individuals who completed the informed consent process and pretest measures. Independent sample *t*-tests and chi-square analyses indicated no significant differences between waitlist and control groups on demographic or pretest study variables. Participants ranged in age from 18 to 35 ($M = 22.89$, $SD = 3.56$, bimodal = 21, 22). Although it was predicted that

Table 2

Timeline of Data Completion for Matched Intervention and Waitlist Groups

Group	Time 1	Time 2	Time 3
Intervention group	Pretest measures	Posttest measures	
Waitlist group	Pretest measures	Control measures	Posttest measures

Table 3

Demographic Characteristics of the Sample

Demographics	<i>n</i>	%
What is your gender identity?		
Female	33	52.4
Male	27	42.9
Other (e.g., Gender queer, female and male, no response)	3	4.7
What is your academic status?		
Freshman	6	9.5
Sophomore	13	20.6
Junior	12	19.0
Senior	21	33.3
Graduate student	5	7.9
Other (e.g. College graduate, second bachelors, non-student)	6	9.5
What is your ethnicity or race? (select all that apply – total > 100%)		
Asian/Asian American	1	1.6
Black/African American	1	1.6
Latino/a, Chicano/a, Hispanic	6	9.5
Native American/American Indian	2	3.2
Middle Eastern	1	1.6
White/Caucasian	57	90.5
To whom are you sexually or romantically attracted?		
Only same sex attracted	7	11.1
Mostly same sex attracted	8	12.7
Equally same sex and other sex attracted	5	7.9
Mostly other sex attracted	10	15.9
Only other sex attracted	32	50.8
Other (e.g., Pansexual)	1	1.6
What label describes your sexual orientation?		
Lesbian/gay	9	14.3
Bisexual	7	11.1
Heterosexual/straight	42	66.7
Other (e.g., Queer, fluid, heteroflexible, no response)	5	7.9
What is your current relationship status?		
Single, not dating	10	15.9
Single, dating casually	18	28.6
Dating someone exclusively	18	28.6
Living with partner	5	7.9
Married	9	14.3
Other (e.g., involuntary celibacy, long-distance relationship, single unspecified)	3	4.7

younger individuals would be most interested in this information, relatively few freshman participated in the study while the largest proportion of participants were college seniors, and many graduate and graduated students were also interested. As may be expected in the region, a majority of participants identified as White/Caucasian. A majority of participants also identified as heterosexual/straight, although a smaller proportion described themselves as exclusively other-sex attracted. The current sample over-represents LGBTQ identified participants as a result of efforts to recruit broadly with regard to sexual orientation. This characteristic of the sample is further explored in the discussion (Chapter V).

Participants also represented a range of relationship statuses from single and not dating to married, with the greatest proportions dating casually or dating one person exclusively. About two thirds of the sample had engaged in sexual intercourse (68.3%, $n = 43$), while slightly less than one third had not (28.6%, $n = 18$) (two participants elected not to respond to this item). A summary of the number of sexual partners that participants reported is found in Table 4. Participants also represented a variety of religious backgrounds and current beliefs, which are summarized in Table 5.

Table 4

Participant Number of Sexual Partners

# of partners	Number	Percent
0	19	30.2
1	15	23.8
2-5	18	28.6
6-10	6	9.5
> 10	4	6.4
No response	1	1.6

Table 5

Participant Religious Background and Beliefs

What are the primary spiritual/religious beliefs of your family, and yourself?	Family		Personal	
	<i>N</i>	%	<i>N</i>	%
Agnostic	-	-	13	20.6
Cahuilla traditions	1	1.6	1	1.6
Catholic	3	4.8	-	-
Christian apostolic	1	1.6	-	-
LDS/Mormon	45	71.4	19	30.2
Pagan	-	-	3	4.8
Protestant (e.g., Baptist, Episcopalian, Methodist, etc.)	5	7.9	3	4.8
None	6	9.5	10	15.9
Other (e.g., Atheist, Hindu, Pantheist, Wiccan)	-	-	9	14.2
Not specified	2	3.2	5	7.9

Group Procedures and Fidelity

Groups were facilitated by female and male coleader pairs to model effective and respectful communication between sexes. Group leaders (all of whom were graduate-level therapists-in-training) were trained by the primary investigator, and experienced the group module-by-module prior to embarking on leading their own groups. Leaders were encouraged to personally explore and examine their own values, beliefs, and misconceptions through this process in order to increase their understanding of the material and its applications as well as increase empathy for the experiences of participants. Training meetings, as well as four additional leader meetings, were supervised by a licensed psychologist.

Based on recommendations listed in the previous chapter as well as the components of healthy sexuality that have been discussed, themes of personal values, boundaries, and communication were discussed throughout the group. Sessions were designed to focus on (a) group introduction, anatomy and sexual response, (b) communication, (c) safer sex practices (e.g., contraception and STI prevention), and (d) preventing unwanted sexual experiences and group reflection. For further information about each session, please see the group manual attached in Appendix C and group handouts in Appendix D. To ensure that all topics outlined were addressed in each session, a fidelity checklist was developed (see Appendix E). This rating form was completed after each session. For each four-session group, two sessions were rated by an observer (the primary investigator or project supervisor) and two sessions were rated by the group's leaders. Topic coverage across all groups averaged 97.69% (min = 92.59%).

Groups ranged from 4 to 10 participants per group (Yalom & Leszcz, 2005) and were composed of roughly equal numbers of male and female participants. The group was well attended by participants, with 71.4% ($n = 40$) of participants attending all four sessions, 19.6% ($n = 11$) attending three sessions, and 8.9% ($n = 5$) attending two sessions. No participants attended fewer than two sessions. Attendance percentages by session may be reviewed in Table 6. Procedures were outlined for the removal of any participants who appeared distressed by the information presented or who were found to be disruptive to the groups, but these actions were never required. Each participant's level of verbal and nonverbal engagement during the group was rated after each session (see fidelity checklist procedures below) on a scale of 1 (Passive, disengaged) to 5

Table 6

Session Attendance and Average Engagement Ratings

Variable	Session 1	Session 2	Session 3	Session 4	Average
Attendance	96.4%	87.5%	91.1%	87.5%	90.6%
Engagement					
Mean	3.57	3.91	3.63	3.67	3.69
SD	0.94	0.75	0.87	0.82	0.75
Range	1-5	2-5	1.5-5	2-5	1.8-5

(active, highly engaged). Averages of these ratings by session and overall (see Table 6) illustrate that participants were actively engaged over the course of the group.

Measures

Participants completed a series of measures prior to participation in and following completion of the group. Those participating in the group completed the first set of measures online prior to the first session of the group, and waitlisted participants were asked to complete the measures during the same week. Group participants completed post-intervention measures following the last session of the group. Waitlisted participants began their group at this time, and completed the measures prior to the first session and again after the last session of the group.

Minor adjustments to item wording were made as appropriate across measures. In some cases this was done to bring the measures “up to date” by using more current terminology, such as changing “venereal diseases/VD” or “sexually transmitted diseases/STDs” to “sexually transmitted infections/STIs.” In other cases, items were

adjusted to increase inclusivity for all sexual orientations, such as changing “boy/girlfriend” to “partner,” and specifying heterosexual intercourse for items regarding birth control.

Demographic Data

Demographic data were collected at time one by self-report, including age, ethnicity, and personal and familial educational history. Participants were also asked to self-report their personal and familial spiritual/religious beliefs, sex/gender, and sexual orientation. Additional information about relationship status and sexual history was also requested. The demographic survey may be reviewed in Appendix F.

Sexuality Education History

Information regarding participants’ sexuality education histories was collected at time one, including 11 items of the Sex Education Inventory and the 20 item Sexual Socialization Instrument. Participants completed the Sexuality Education Program Feature/Program Outcome Inventory at pretest (regarding their high school experiences of sexuality education) and at posttest (regarding their experiences in the group).

Sex Education Inventory

The Sex Education Inventory (SEI) surveys individual’s preferred and actual ratings of sexuality education, family environment, and sexual learning (Bennett & Dickinson, 1998). The measure includes standard multiple choice and open-ended questionnaire items. Respondents select their preferred and actual sources of information

about various sexuality education topics from a list of possible sources (items 1-10). More detailed information on sex-related topics discussed with each parent and/or studied in high school or college is assessed by a checklist of 16 topics (item 11). Personal satisfaction with sexuality education and current knowledge of things pertaining to sex is measured using two 7-point, Likert-type items (items 45 and 46, renumbered 12 and 13). Respondents are asked to indicate whether they would handle their children's sexuality education similarly to their own sexuality education ("yes" or "no," item 47, renumbered 14), and were also asked to expand on this response in the present study ("why or why not?"). Further items in the measure assess relationships with mother and father and engagement in sexual activities. However these constructs were assessed in other ways for the purposes of this study, and therefore these SEI items were omitted. Coefficients of stability have been reported as .80 and .89 for items 1-10 ($N = 55$, interval = 4 weeks), .87 for item 11 ($N = 55$, interval = 2 weeks), and .88 and .90 for items 45 and 46 ($N = 27$; Bennett & Dickinson, 1998). The items used in the present study take about 5 minutes to complete, and may be reviewed in Appendix G.

Sexual Socialization Instrument

The Sexual Socialization Instrument (SSI) measures permissive sexual influences of parents and peers on adolescents and young adults (Lottes & Kurlioff, 1998), that is, acceptance of nonmarital sexual interactions. The SSI consists of two scales, the Parental Sexual Socialization Scale and the Peer Sexual Socialization Scale, made up of 8 and 12 items, respectively. Respondents indicate their agreement or disagreement with each item statement using a 5-point Likert-type scale. Cronbach alphas for the parental and peer

scales have been found to be .78 and .85, respectively (Lottes & Kurlioff, 1998). In the present analyses, a floor effect occurred for the parental scale, indicating that participants uniformly perceived parental attitudes as sexually conservative, resulting in an unacceptably low Cronbach alpha (.41). The peer scale alpha (.87) was acceptable, although mean scores indicated that peers were also disapproving of promiscuity. Based on these achieved alpha levels the parental scale was dropped from further analyses, while the peer scale was retained. The SSI takes about 5 minutes to complete, and may be reviewed in Appendix H.

Sexuality Education Program Feature/ Program Outcome Inventory

This inventory is intended to evaluate the impact of sexuality education programs on students by examining self-reported changes in knowledge, attitudes, and behaviors (Klein, 1998). The inventory consists of 69 items relating to sexuality education. For the purposes of the present analyses, the measure was divided into three scales based on the structure of the inventory. The first twelve items of the inventory, conceptualized as the Teacher Characteristics scale, examine program characteristics influenced by the instructor including classroom atmosphere, encouragement to examine and discuss one's personal values, and the instructor's relationship with students. The next 19 items each begin with the stem "As a result of your high school sexual education, do you feel you have a *greater understanding of...*" (19 potential sexuality education topics) and have been grouped here as the Understanding scale. Likewise, the subsequent fourteen items, grouped here as the Ability scale, each began with the stem "As a result of your high

school sexual education, do you feel you have *a greater ability to...*” (engage in various behaviors, e.g., make decisions, communicate feelings, discuss sexual behavior with partner, etc.). These 45 items are responded to using a Likert-type scale with options ranging from *strongly agree* to *strongly disagree*, with an additional option of *don't know*.

The 13 remaining items pertain to curriculum implementation of several important topics in sexuality education (e.g., anatomy and physiology, the range of sexual behaviors, sexually transmitted infections) and are examined using a nominal scale. Response options include *Formally covered* (the topic was discussed in a class period or unit in which the teacher presented information through lecture, discussion, class activity, media, or guest speaker), *Informally covered* (the topic was discussed only if a student asked a question about it), *Not at all* (the topic was not discussed), or *Don't Know* (not enough information to respond to the statement).

The face validity of the inventory has been supported by a review panel, and Cronbach's alpha for the total inventory is .88 (Klein, 1998). Each of the scales developed for the current study achieved excellent reliability: Teacher characteristics (.91), Understanding (.92), and Abilities (.94). The inventory takes about 10 minutes to complete, and may be reviewed in Appendix I.

Mathtech Questionnaires

The Mathtech Questionnaires were developed using funds from the Center for Disease Control with two purposes: (a) to measure knowledge, attitudes, values, skills,

and behavior that facilitate characteristics of healthy sexuality; and (b) to measure outcomes of sexuality education programs (Kirby, 1984, 1998). The set of questionnaires is composed of the Knowledge Test, the Attitude and Value Inventory, and the Behavior Inventory, all of which may be reviewed in Appendix J. Participants completed the Mathtech questionnaires at time one (prior to the first session of the group) and time two (following the last session of the group). Waitlist participants additionally completed the measure during the week of the first session for their comparison group.

Knowledge Test

The Knowledge Test is a 34-item multiple-choice test. Topics examined include: adolescent physical development, relationships, sexual activity, pregnancy, marriage, birth control, and sexually transmitted infections. The test has been used successfully with junior and senior high school students. Validity of the test has been supported, with older students obtaining higher scores than younger students in secondary educational settings, as well as students with higher GPA scores scoring higher on the test than those with lower GPA scores, and by expert consultation during the development of the test. Test-retest reliability is .89 (Kirby, 1998). The Knowledge Test takes approximately ten to twenty minutes to complete. Scores are calculated as the number of items correct, or as a percent correct.

Attitude and Value Inventory

The Attitude and Value Inventory is a 70-item inventory with statements scored on a 5-point Likert-type scale ranging from *Strongly disagree* to *Strongly agree*, with a

Neutral midpoint. The inventory is composed of 14 scales including constructs such as clarity of personal sexual values, understanding of personal sexual response, attitude toward sexuality in life, attitude toward premarital sex, attitude toward the use of force and pressure in sexual activity, self-esteem, and satisfaction with personal sexuality. Reliability coefficients reported by Kirby (1998) on the scales range from .58 to .94 (avg = .77). A summary of the reliability coefficients for these scales in the present study may be found in Table 7. Several scales yielded reliability estimates less than .70 at one or more time points. Although all scales were retained for analyses, scales that demonstrated questionable reliability are identified in italics throughout the presentation of results, and results should be interpreted cautiously. As poor reliability functions to introduce additional error into analyses, and actually limits the ability to detect significant

Table 7

Chronbach's Alphas for Attitudes and Values Inventory Scales

Scale	Pretest	Waitlist	Posttest
Clarity of long-term goals	.92	.92	.89
<i>Clarity of personal sexual values</i>	.87	.76	.49
Understanding of emotional needs	.92	.85	.73
Understanding of personal social behavior	.79	.79	.82
<i>Understanding of personal sexual response</i>	.88	.75	.62
<i>Attitude toward gender roles</i>	.59	.77	.78
<i>Attitude toward sexuality in life</i>	.57	.67	.53
<i>Attitude toward the importance of birth control</i>	.58	.54	.37
Attitude toward premarital sex	.98	.99	.97
<i>Attitude toward the use of force and pressure in sexual activity</i>	.04	.20	.14
<i>Recognition of the importance of the family</i>	.71	.64	.78
Self-esteem	.92	.92	.92
Satisfaction with personal sexuality	.94	.82	.92
Satisfaction with social relationships	.91	.92	.94

Note. Scales in italics identified for poor reliability in further analyses.

differences or relationships, those scales with more questionable reliability were still considered viable for interpretation. The Attitude and Value Inventory takes approximately 10-15 minutes to complete.

Behavior Inventory

The Behavior Inventory is a 54-item² inventory examining three aspects of behavior: the skill with which the behavior is completed, the degree of comfort in carrying out that behavior, and the frequency of the behavior. The inventory consists of multiple scales across these three aspects. Skill scales include: social decision-making, sexual decision-making, communication, assertiveness, birth control assertiveness, and STI protection assertiveness. Questions assessing skill are intended to measure the frequency with which respondents actually use the skills, rather than classroom knowledge of the skills. These 26 items are responded to using a 5-point scale ranging from *almost always* to *almost never*. Test-retest reliability correlation coefficients for these scales range from .57 to .88 (interval = 2 weeks) and Cronbach's alphas range from .58 to .75 (Kirby, 1998).

Comfort scales include engaging in social activities, talking with friends, partner(s), and parents about sex, birth control, and STI protection (based on parallel items created by the researcher), being sexually assertive (saying "no"), having current sex life, and getting and using birth control and STI protection. These 25 items are

²While many items in the inventory address behaviors associated with birth control, no questions address STI prevention. Parallel items have been generated to include STI prevention assertiveness, communication, and use, making the inventory 68-items in length.

responded to using a 4-point scale ranging from *comfortable* to *very uncomfortable*. Test-retest reliability correlation coefficients for these scales range from .40 to .70 (interval = 2 weeks) and Cronbach's alphas range from .63 to .86 (Kirby, 1998). A summary of the reliability coefficients for skill and comfort scales in the present study may be found in Table 8. As with the scales for the sexual attitudes, behavior scales that demonstrated alphas lower than .70 for any of the time points were retained for analyses, but were identified in italics in subsequent summaries. Scales measuring comfort talking about

Table 8

Cronbach's Alphas for Behavior Inventory Scales

Scale	Pretest	Waitlist	Posttest
<i>Social decision-making skills</i>	.45	.66	.45
<i>Sexual decision-making skills</i>	.68	.88	.63
Communication skills	.73	.74	.78
<i>Assertiveness skills</i>	.61	.72	.53
<i>Birth control assertiveness skills</i>	.40	.64	.51
STI protection assertiveness skills	.73	.90	.75
Comfort engaging in social activities	.84	.79	.80
<i>Comfort talking with parents, friends, and partners about sex</i>	.67	.49	.47
<i>Comfort talking with parents, friends, and partners about birth control</i>	.73	.47	.58
<i>Comfort talking with parents, friends, and partners about STI protection</i>	.73	.65	.44
Comfort talking with parents about sex, birth control, and STI protection	.90	.95	.97
Comfort talking with friends about sex, birth control, and STI protection	.87	.86	.89
Comfort talking with partners about sex, birth control, and STI protection	.88	.79	.93
<i>Comfort being sexually assertive (saying "no")</i>	.61	.64	.60
<i>Comfort getting and using birth control</i>	.67	.58	.81
<i>Comfort getting and using STI protection</i>	.84	.63	.84

Note. Scales in italics identified for poor reliability in further analyses.

issues by topic (e.g., comfort talking to parents, friends, and partners about sex) were dropped in favor of scales measuring comfort discussing these topics in particular forms of relationships (e.g., comfort talking with partners about sex, birth control, and STI protection).

Questions measuring sexual activity, use of birth control (and STI prevention devices), and frequency of communication ask how many times during the previous month the respondent engaged in the activity. Test-retest reliability correlation coefficients observed during original scale development ranged from .69 to 1.0 ($N = 41$, interval = 2 weeks). It should be noted that these coefficients are artificially low for some items because the sexual activities of teenagers (the sample group) change from one two-week period to the next.

The Behavior Inventory takes approximately 20 minutes to complete, though respondents who are not sexually active are likely to complete it more quickly.

CHAPTER IV

RESULTS

As stated in chapter two, the goals of the present study included gaining an understanding of college students' sexuality education histories, their knowledge and attitudes about human sexuality, and their current sexual behaviors. Additionally, we were interested to see what changes occurred with regard to knowledge, attitudes, and behaviors as a result of participation in a psychoeducational healthy sexuality group, and how participants viewed the present group in comparison to their high school sexuality education experiences. Specific research questions were as follows.

1. What is the sexuality education history of typical college students?
 - a. Who are their primary sources of sexual information? Who are their preferred sources?
 - b. What have been their parents' and peers' attitudes regarding sexuality?
 - c. How do they describe their school-based sexuality education experiences?
2. What sexual knowledge, attitudes, and experiences are characteristic of college students?
 - a. What level of basic sexual knowledge do college students have? How accurate is this knowledge?
 - b. What attitudes do college students hold regarding human sexuality?
 - c. What sexual behaviors are college students engaging in (e.g., frequency of partnered sexual activities, communication with partners regarding sexual matters)?

3. What are the effects of and reactions to the designed intervention?
 - a. Are their changes in the domains of knowledge, attitudes, or behavior as a result of the intervention?
 - b. How do participants' evaluations of this intervention compare to their evaluations of prior sexuality education experiences?

RQ1.a Preferred and Actual Sources of Information

The first research question addressed the sexuality education history of the participants. This question was conceptualized to address not only formal, school-based educational experiences, but also education that may have come from family, friends, or other sources.

To begin with, participants were asked (via the SEI) to indicate who they believed should have primary responsibility for teaching young people about a variety of topics related to sex, including sex in general, birth control, sexually transmitted infections (STIs), moral and ethical questions related to sex, and interpersonal relations and sexuality (see Table 9). For all of these topics, the largest proportion of participants identified parents as the preferred source of information. Despite these preferences, participant responses indicated that parents were not the primary source of information about these topics for most individuals. When parents were identified as the source of information, mothers were much more often responsible for education than fathers. Participants were able to expand on these responses by indicating with whom they had discussed particular topics, and where they had studied each topic (see Table 10).

Table 9

Preferred and Actual Sources of Sexuality Information

Source of information	Preferred source		Actual source	
	<i>N</i>	%	<i>N</i>	%
Who should have primary responsibility for teaching young people about sex in general?				
Female friends	-	-	6	9.5
Male friends	-	-	7	11.1
Parents	44	69.8	10	16.5
Mother	-	-	9	14.9
Father	-	-	1	1.6
Other family members	-	-	1	1.6
Professional sex educators or counselors	9	14.3	2	3.2
Teachers (content of schoolwork)	7	11.1	6	9.5
Minister, priest, or other religious leader	-	-	1	1.6
Media (e.g., radio, televisions)	-	-	7	11.1
Reading on my own	-	-	21	33.3
No one special	3	4.8	2	3.2
Who should have primary responsibility for teaching young people about birth control?				
Female friends	-	-	13	20.6
Male friends	-	-	1	1.6
Parents	33	52.4	5	7.9
Mother	-	-	3	4.8
Father	-	-	2	3.2
Sister	-	-	1	1.6
Professional sex educators or counselors	15	23.8	5	7.9
Physicians and/or nurses	4	6.3	9	14.3
Teachers (content of schoolwork)	9	14.3	10	15.9
College (e.g., courses, clubs)	-	-	2	3.2
Media (e.g., radio, televisions)	-	-	3	4.8
Reading on my own	-	-	12	19.0
No one special	2	3.2	2	3.2

(table continues)

Source of information	Preferred source		Actual source	
	<i>N</i>	%	<i>N</i>	%
Who should have primary responsibility for teaching young people about recognizing and preventing STIs?				
Female friends	-	-	1	1.6
Parents	23	36.5	-	-
Professional sex educators or counselors	16	25.4	8	12.7
Physicians and/or nurses	4	6.3	3	4.8
Teachers (content of schoolwork)	19	30.2	33	52.4
Media (e.g., radio, televisions)	-	-	4	6.3
Reading on my own	-	-	11	17.5
No one special	1	1.6	3	4.8
Who should have primary responsibility for teaching young people about moral and ethical questions related to sex?				
Female friends	-	-	1	1.6
Male friends	-	-	2	3.2
Parents	52	82.5	16	25.4
Mother	-	-	12	19.0
Father	-	-	3	4.8
Professional sex educators or counselors	2	3.2	1	1.6
Teachers (content of schoolwork)	1	1.6	-	-
Minister, priest, or other religious leader	1	1.6	19	30.2
Media (e.g., radio, televisions)	-	-	3	4.8
Reading on my own	-	-	10	15.9
No one special	7	11.1	11	17.5
Who should have primary responsibility for teaching young people about interpersonal relations and sexuality?				
Female friends	-	-	12	19.0
Male friends	-	-	5	7.9
Parents	41	65.1	12	19.0
Mother	-	-	12	19.0
Spouse	-	-	1	1.6
Professional sex educators or counselors	10	15.9	2	3.2
Teachers (content of schoolwork)	3	4.8	4	6.3
Minister, priest, or other religious leader	-	-	1	1.6
Media (e.g., radio, televisions)	-	-	3	4.8
Reading on my own	-	-	11	17.5
No one special	9	14.3	12	19.0

Table 10

Sources of Information About Sexual Topics

Topic	Discussed with				Studied in				None of these	
	Mother		Father		High school		College		N	%
	N	%	N	%	N	%	N	%		
Sexually transmitted infections (STIs)	12	19.0	4	6.3	47	74.6	18	28.6	8	12.7
Personal hygiene	39	61.9	20	31.7	34	54.0	8	12.7	9	14.3
Menstruation	35	57.1	6	9.5	39	61.9	14	22.2	9	14.3
Pregnancy and delivery	27	42.9	5	7.9	42	66.7	25	39.7	10	15.9
Intercourse	26	41.3	17	27.0	29	46.0	20	31.7	13	20.6
What to look for in a mate	43	68.3	33	52.4	8	12.7	11	17.5	15	23.8
What to do to prevent STIs	13	20.6	7	11.1	39	61.9	19	30.2	16	25.4
Birth control	19	30.2	7	11.1	28	44.4	20	31.7	18	28.6
Homosexuality	24	38.1	21	33.3	13	20.6	25	39.7	19	30.2
Specific methods of birth control	13	20.6	4	6.3	19	30.2	19	30.2	21	33.3
Abortion	23	36.5	17	27.0	21	33.3	14	23.8	23	36.5
“How far to go” on a date	31	49.2	18	28.6	10	15.9	5	7.9	27	42.9
Where to go for help if you suspect STIs	6	9.5	1	1.6	20	31.7	16	25.4	31	49.2
Where to go for birth control information	11	17.5	2	3.2	15	23.8	18	28.6	32	50.8
Masturbation	12	19.0	11	17.5	11	17.5	10	15.9	35	55.6
Orgasm	4	6.3	1	1.6	10	15.9	17	27.0	38	60.3

Participants could select multiple responses for each item, or “none of these.” All of the topics were more frequently discussed with mothers than fathers. Both parents seemed to be involved in discussions of what to look for in a mate, “how far to go” on a date, and personal hygiene. Fathers were less likely to be involved in discussions of reproductive health, such as menstruation, pregnancy, birth control and birth control methods and information. Fathers were also less likely to be involved in discussions of STIs, STI

prevention, and what to do in case of STIs. Most topics were more frequently studied in high school than college (although the majority of participants were still enrolled in college), with few exceptions. Although a larger percentage of individuals had studied birth control in high school, specific methods and where to go for birth control information were investigated more during college. College was also a more likely setting for studying orgasm, homosexuality, and what to look for in a mate. For large proportions of participants, none of these sources had provided information on many of these topics. Examples of these topics include orgasm, masturbation, and where to go for birth control information or in case of STIs.

RQ1.b Parental and Peer Attitudes Regarding Sexuality

As described in Chapter III, parents were perceived by participants as extremely nonpermissive regarding nonmarital sexual interactions, resulting in a range of responses so constricted to the “disapproving” end of the scale that reliability was unacceptable for this scale (possible range = 8-40; actual range = 8-29). Range of responses for peer items were skewed to the “disapproving” end of the scale but utilized most of the range (possible = 12-60; actual = 12-58), and achieved an acceptable reliability alpha. Participants also perceived peers as nonpermissive influences ($M = 24.14$, $SD = 8.42$). Overall, findings illustrate that participants perceived their parents in particular, and their peers to a somewhat lesser extent, to “discourage casual sexual encounters and promote either abstinence or sex for individuals only in loving, long-term relationships” (Lottes & Kurlioff, 1998, as cited in Davis, Yarber, Bauserman, Schreer, & Davis, 1998, p. 494).

RQ1.c Characteristics of School-Based Sexuality Education

Participants were asked to describe their school-based sexuality education experiences in greater detail. The majority of the sample attended public high school ($n = 59, 93.7\%$). Two participants attended charter high schools, one attended a private high school, and one was homeschooled. Over half of the sample had never had a class focused on human sexuality (52.4%). About one third of the sample had a class focused on human sexuality in high school (34.9%) or in junior high (3.49%), and about a quarter had a class in both (23.8%). However, it was unclear whether these responses discriminate between having an entire course or course module dedicated to sexuality education so these findings should be interpreted with caution.

Participants were asked to evaluate a variety of aspects of their high school sexuality education. Items examined teacher characteristics (e.g., enthusiasm, openness, encouragement), the extent to which programs improved understanding of a variety of topics, and the extent to which programs impacted participants' perceived ability to engage in a variety of personal behaviors (see Table 11), as well as the manner in which topics were presented (see Table 12).

Results on the three generated scales illustrate the wide variety of experiences that college students recall regarding their sexuality education. Higher scores on these scales indicate more positive ratings in each domain. The full range from 1-4 was utilized on two out of three of these scales (understanding and ability), and the teacher characteristics range was nearly as large. This indicates that while some students felt that their instructors effectively facilitated learning, that their understanding was improved, and

Table 11

Ratings of Teacher Characteristics, Understanding, and Abilities

Variable	Teacher characteristics		Understanding		Ability	
	Past course(s) (n = 54)	Group (n = 56)	Past course(s) (n = 61)	Group (n = 56)	Past course(s) (n = 58)	Group (n = 56)
Mean	2.57	3.28	2.40	3.71	2.39	3.53
SD	0.64	0.46	0.59	0.29	0.66	0.42
Minimum	1.25	1.79	1.00	3.08	1.00	2.43
Maximum	3.83	4.00	4.00	4.00	4.00	4.00
Skewness	-0.12	-0.66	.20	-0.72	0.11	-0.54
Std. error of skew	0.33	0.32	0.31	0.32	0.31	0.32

Note. Range = 1-4.

that they felt a greater sense of efficacy regarding particular skills, other students had vastly different experiences. Post-group evaluation data indicates that participants tended to rate their experiences in the group more positively than their historical experiences (a finding discussed further below: see RQ3.b).

Regarding coverage of course topics, responses indicate that sexually transmitted infections were covered most formally, followed by biological aspects of reproduction, anatomy and physiology, and avoiding unwanted sexual experiences. Aspects of contraceptive methods, including effectiveness, advantages, and disadvantages, were covered formally in about a quarter of programs and informally in another quarter. Participants' reports demonstrate that these topics were not covered at all in nearly half of their experiences. Six of the listed topics were not covered at all in more than half of the samples' experiences. These included intrapersonal aspects of sexuality, such as the relationship between self-esteem and behavior and sexuality as an aspect of one's total personality, student feelings about sexual activity, student feelings and attitudes about sex roles, and the range of sexual behaviors.

Table 12

Formality with Which Specific Topics Were Covered In Sexuality Education Programs

Topic	Formally covered		Informally covered		Not at all		Don't know	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Sexually transmitted infections.	87.3	55	4.8	3	1.6	1	6.4	4
Biological aspects of human reproduction.	73.0	46	11.1	7	6.3	4	9.5	6
Anatomy and physiology.	65.1	41	17.5	11	7.9	5	9.5	6
Avoiding unwanted sexual experiences.	54.0	34	19.0	12	19.0	12	7.9	5
Peer pressure and sexual behavior.	54.0	34	22.2	14	17.5	11	6.4	4
Adolescent pregnancy	50.8	32	28.6	18	12.7	8	7.9	5
The probability of becoming pregnant.	41.3	26	31.7	20	15.9	10	11.1	7
Improving decision-making skills.	34.9	22	25.4	16	28.6	18	11.1	7
Advantages of the various contraceptive methods.	27.0	17	19.0	12	44.4	28	9.5	6
The effectiveness of the various contraceptive methods.	27.0	17	22.2	14	39.7	25	11.1	7
Improving problem-solving skills.	23.8	15	20.6	13	39.7	25	15.9	10
Disadvantages of the various contraceptive methods.	20.6	14	23.8	15	44.4	28	11.1	7
The social needs during adolescence.	19.0	12	34.9	22	33.3	21	12.7	8
Improving communication skills with peers.	17.5	11	27.0	17	42.9	27	12.7	8
The emotional needs during adolescence.	15.9	10	33.3	21	36.5	23	14.3	9
Common myths concerning sexuality.	14.3	9	23.8	15	47.6	30	14.3	9
Students' attitudes about sexual activity.	12.7	8	27.0	17	49.2	31	11.1	7
Improving communication skills with parents.	12.7	8	27.0	17	46.0	29	14.3	9
The relationship between feelings about oneself and one's behavior.	12.7	8	23.8	15	52.4	33	11.1	7
Human sexuality as an aspect of one's total personality.	9.5	6	9.5	6	68.3	43	12.7	8
The range of sexual behaviors.	9.5	6	11.1	7	71.4	45	7.9	5
Students' feelings about sexual activity.	7.9	5	20.6	13	61.9	39	9.5	6
Students' attitudes about sex roles.	6.3	4	19.0	12	65.1	41	9.5	6
Students' feelings about sex roles.	4.8	3	11.1	7	69.8	44	14.3	9

Finally, participants were asked to indicate how satisfied they were with the way(s) in which they found out most of what they knew about things having to do with sex and their current knowledge about things having to do with sex. Satisfaction was

rated on a scale from very dissatisfied (1) to very satisfied (7). The mean score for satisfaction for the ways learned was 3.9, and for current knowledge was 5.2. A bar chart displaying the frequency distribution of responses to these items is found in Figure 2.

Participants were also asked “Would you handle your own children’s sex education pretty much the same way yours was handled?” The majority of the sample answered “No” ($n = 51, 81.0\%$), while some answered “Yes” ($n = 7, 11.1\%$) and others couldn’t say ($n = 5, 7.9\%$). Participants were invited to elaborate on these responses in open-ended format. Some of these statements are included below.

“No...I feel like my ignorance leads to negative feelings and insecurity regarding sex.”

“No...I wouldn’t want them to think it’s a mysterious thing that nobody talks about. I wouldn’t want to leave them in the dark.”

“Yes...My parents taught me in an open environment so that I felt comfortable enough to tell them anything and ask them anything. I would love to have the same relationship with my future children.”

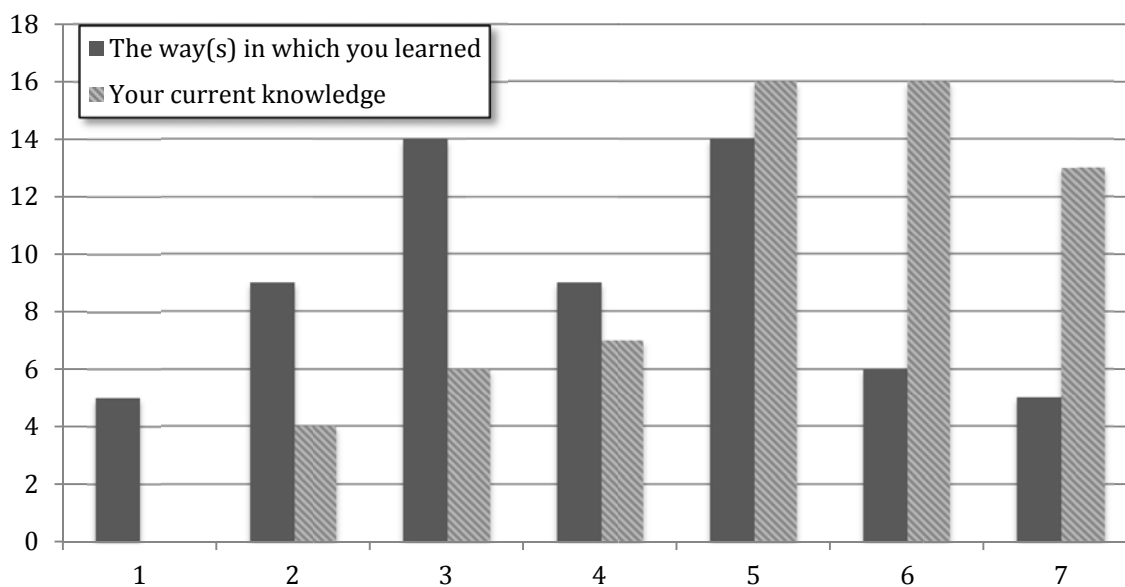


Figure 2. Satisfaction with knowledge acquisition and current knowledge.

“No...I would prefer to be a lot more open about sex ed, STIs, pregnancy, LGBTQ issues, etc. than my parents were.”

“No... I have done much personal reading on the topic, which is a very daunting thing to do as Googling could easily have yielded graphic material or misinformation. If someone ‘safe’ could have provided materials for me I would have been able to avoid that scary way of getting the info.”

“Yes... My parents were always very open about sex as a reality of life and something that is to be enjoyed and held special.”

RQ2.a Sexual Knowledge Accuracy

Participant scores on the Mathtech Knowledge Questionnaire prior to intervention were widely varied (see Table 13). Average knowledge accuracy was less than 75%, with individual scores ranging from as low as 45% to as high as 95%. Scores improved following the group intervention, with average accuracy increasing to 80% and the low end of the range improving to about 60% accuracy (this change is further discussed in relation to research question 3).

Closer examination of the most frequently missed items (see Table 14) revealed

Table 13

Knowledge Accuracy Scores Across Time

Variable	Pretest (<i>n</i> = 63)		Waitlist (<i>n</i> = 29)		Posttest (<i>n</i> = 57)	
	Raw	Percent	Raw	Percent	Raw	Percent
Mean	16.14	73.42	16.46	74.49	17.58	79.95
<i>SD</i>	2.26	10.35	2.08	9.56	1.89	8.62
Minimum	10	45.45	13	59	13	59.09
Maximum (total items = 22)	21	95.45	20	91	21	95.45
Skewness	-0.35	-0.33	-0.22	-0.10	-0.42	-0.42
Std. error of skew	0.30	0.30	0.46	0.46	0.32	0.32

Table 14

Most Frequently Missed Items (Percentage Answering Incorrectly)

Item	Pretest (<i>n</i> = 63)		Waitlist (<i>n</i> = 29)		Posttest (<i>n</i> = 57)	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
The proportion of American girls who become pregnant before turning 20 is: a. 1 out of 3 (best response) b. 1 out of 11 c. 1 out of 43 d. 1 out of 93	81.0	51	84.6	22	70.2	40
If a heterosexual couple has sexual intercourse and uses no birth control, the woman might get pregnant: a. Anytime during the month (best response) b. Only 1 week before menstruation begins c. Only during menstruation d. Only 1 week after menstruation begins e. Only 2 weeks after menstruation begins	60.3	38	50.0	13	21.1	12
It is impossible now to cure: a. Syphilis b. Gonorrhea c. Herpes virus #2 (best response) d. Vaginitis e. All of the above	60.3	38	46.2	12	47.4	27
If 10 heterosexual couples have sexual intercourse regularly without using any kind of birth control, the number of couples who become pregnant by the end of 1 year is about: a. One b. Three c. Six d. Nine (best response) e. None of the above	58.7	37	61.5	16	56.1	32
When unmarried young women learn they are pregnant, the largest group of them decide: a. To have an abortion b. To put the child up for adoption c. To raise the child at home (best response) d. To marry and raise the child with the husband e. None of the above	57.1	36	53.8	14	45.6	26
By the time teenagers graduate from high schools in the United States: a. Only a few have had sex b. About half have had sex (best response) c. About 80% have had sex	44.4	28	42.3	11	45.5	26

(table continues)

Item	Pretest (<i>n</i> = 63)		Waitlist (<i>n</i> = 29)		Posttest (<i>n</i> = 57)	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Gonorrhea:	44.4	28	42.3	11	31.6	18
a. Is 10 times more common than syphilis						
b. Is a disease that can be passed from mothers to their children during birth						
c. Makes men and women sterile (unable to have babies)						
d. Is often difficult to detect in women						
e. All of the above (best response)						
The rhythm method (natural family planning):	44.4	28	26.9	7	26.3	15
a. Means couples cannot have intercourse during certain days of the woman's menstrual cycle						
b. Requires the woman to keep a record of when she has her period						
c. Is effective less than 80% of the time						
d. Is recommended by the Catholic church						
e. All of the above (best response)						
Syphilis:	33.3	21	23.1	6	21.1	12
a. Is one of the most dangerous STIs						
b. Is known to cause blindness, insanity, and death if untreated						
c. Is first detected as a chancre sore on the genitals						
d. All of the above (best response)						

that there were five items that more than half of the sample answered incorrectly at pretest, and another four items missed by over a third. Of note, many of these items concerned pregnancy risk and contraceptive methods among heterosexual couples. This is particularly troubling as the majority of the sample identified as heterosexual, yet appeared not to know their own levels of risk based on these findings.

Although pretest knowledge accuracy was relatively low, the majority of participants indicated that they were primarily satisfied with their current levels of sexual knowledge (see Figure 1). Of note, participants rated their knowledge satisfaction before completing the knowledge test. Correlations between reported knowledge satisfaction and knowledge accuracy were examined, but were not significant ($r = -0.01$). This finding is

particularly concerning, as it suggests that young people's satisfaction with their sexual knowledge is completely unrelated to the accuracy of that knowledge.

RQ2.b Attitudes and Values Regarding Sexuality

Overall, it appears that participants had relatively positive attitudes on most of the Attitudes and Values Inventory scales (see Table 15), with higher scores representing more favorable attitudes. Over time, participants' attitudes seemed to improve somewhat with range floors being raised, and low outliers moving towards the majority of participants, who tended to skew in the direction of positive attitudes. An exception to this trend occurred on the Attitude Toward Premarital Sex scale, for which the mean score fell toward the less favorable end of the scale.

Some scales were so significantly skewed at pretest that they were removed from analyses altogether, such as Attitude Toward the Importance of Birth Control (with participants overwhelmingly supporting the use of contraception) and Attitude Toward the Use of Force and Pressure in Sexual Activity (with participants overwhelmingly opposing the use of force and pressure). Because attitudes were so strong on these scales and in line with the curriculum of the designed group, no significant change in these areas could be expected.

RQ2.c Sexual Behaviors

The third component of this research question asked about the sexual behaviors in which college students are engaged. Behaviors were measured using the Mathtech Behavior Inventory, which is composed of multiple scale scores regarding behavioral

Table 15

Attitudes and Values Inventory Means, Standard Deviations, and Skewness

Scale (possible range = 1-5)	Pretest (n = 63)	Waitlist (n = 29)	Posttest (n = 56)
<i>Clarity of long-term goals</i>			
Mean (SD)	3.86 (1.03)	4.05 (0.75)	4.10 (0.82)
Skewness (error)	-1.12 (0.30)	-0.54 (0.43)	-0.79 (0.32)
Range	1-5	2.2-5	1.8-5
<i>Clarity of personal sexual values</i>			
			(n = 55)
Mean (SD)	3.91 (0.93)	4.14 (0.72)	4.26 (0.68)
Skewness (error)	-0.94 (0.30)	-1.06 (0.43)	-1.47 (0.32)
Range	1.5-5	2.4-5	1.75-5
<i>Understanding of emotional needs</i>			
Mean (SD)	3.71 (0.92)	4.04 (0.61)	4.10 (0.64)
Skewness (error)	-0.97 (0.30)	-0.13 (0.43)	-0.56 (0.32)
Range	1-5	2.75-5	2.4-5
<i>Understanding of personal social behavior</i>			
Mean (SD)	3.93 (0.74)	4.12 (0.58)	4.13 (0.66)
Skewness (error)	-0.60 (0.30)	-0.24 (0.43)	-0.71 (0.32)
Range	2-5	3-5	2.2-5
<i>Understanding of personal sexual response</i>			
		(n = 26)	
Mean (SD)	3.66 (0.95)	4.13 (0.57)	4.15 (0.70)
Skewness (error)	-0.70 (0.30)	-0.36 (0.46)	-0.82 (0.32)
Range	1-5	3-5	2-5
<i>Attitude toward gender roles</i>			
Mean (SD)	4.61 (0.52)	4.46 (0.79)	4.68 (0.52)
Skewness (error)	-2.14 (0.30)	-1.80 (0.43)	-2.05 (0.32)
Range	2.5-5	2-5	2.6-5
<i>Attitude toward sexuality in life</i>			
	(n = 59)	(n = 28)	(n = 51)
Mean (SD)	4.30 (0.65)	4.41 (0.48)	4.52 (0.50)
Skewness (error)	-1.45 (0.31)	-0.98 (0.44)	-1.37 (0.33)
Range	2-5	3-5	3-5
<i>Attitude toward the importance of birth control</i>			
Mean (SD)	4.78 (0.39)	4.85 (0.31)	4.93 (0.22)
Skewness (error)	-2.30 (0.30)	-2.05 (0.43)	-3.54 (0.32)
Range	3-5	4-5	3.8-5
<i>Attitude toward premarital sex</i>			
Mean (SD)	2.20 (1.30)	2.07 (1.32)	2.11 (1.25)
Skewness (error)	0.91 (0.30)	1.24 (0.43)	0.99 (0.32)
Range	1-5	1-5	1-5

(table continues)

Scale (possible range = 1-5)	Pretest (n = 63)	Waitlist (n = 29)	Posttest (n = 56)
<i>Attitude toward the use of force and pressure in sexual activity</i>			
Mean (SD)	4.90 (0.24)	4.92 (0.20)	4.93 (0.20)
Skewness (error)	-2.38 (0.30)	-3.77 (0.43)	-3.45 (0.32)
Range	4.20-5	4-5	4-5
<i>Recognition of the importance of the family (n = 61)</i>			
Mean (SD)	4.75 (0.36)	4.59 (0.51)	4.75 (0.48)
Skewness (error)	-1.56 (0.31)	-1.20 (0.43)	-2.89 (0.32)
Range	3.6-5	3.25-5	2.67-5
<i>Self-esteem</i>			
Mean (SD)	3.76 (1.07)	4.14 (0.78)	4.13 (0.90)
Skewness (error)	-0.73 (0.30)	-1.62 (0.44)	-1.53 (0.32)
Range	1.4-5	1.8-5	1.4-5
<i>Satisfaction with personal sexuality (n = 60)</i>			
Mean (SD)	3.58 (1.18)	3.92 (0.69)	3.89 (0.97)
Skewness (error)	-0.64 (0.31)	-0.50 (0.46)	-1.03 (0.32)
Range	1-5	2.25-5	1.2-5
<i>Satisfaction with social relationships (n = 61)</i>			
Mean (SD)	3.89 (0.97)	3.83 (1.00)	3.93 (1.01)
Skewness (error)	-0.69 (0.31)	-0.99 (0.46)	-0.90 (0.33)
Range	1.4-5	1.4-5	1.2-5

Note. Scales in italics identified for poor reliability

engagement and comfort, as well as self-reported frequency of engagement in a variety of behaviors.

Scores for behavioral engagement scales (see Table 16) range from a possible 1 (“If you do it *almost never*, which means about 5% of the time or less”) to 5 (“If you do it *almost always*, which means about 95% of the time”). Overall, results indicated that participants were largely confident in their usage of skills across the measure. Participants were more confident in their social decision-making skills than their sexual decision-making skills. They were more confident in their assertiveness skills than communication skills in general, and were extremely confident in their birth control assertiveness although less so regarding STI assertiveness. It should be noted that large

Table 16

Behavioral Engagement Means, Standard Deviations, and Skewness

Scale (Possible range = 1-5)	Pretest (<i>n</i> = 62)	Waitlist (<i>n</i> = 27)	Posttest (<i>n</i> = 56)
<i>Social decision-making skills</i>			
Mean (<i>SD</i>)	4.18 (0.47)	4.29 (0.49)	4.34 (0.43)
Skewness (error)	-0.76 (0.30)	-0.77 (0.45)	-1.24 (0.32)
Range	2.8-5	3-5	2.67-5
<i>Sexual decision-making skills</i> (<i>n</i> = 60)			
Mean (<i>SD</i>)	3.84 (0.69)	4.02 (0.94)	4.01 (0.69)
Skewness (error)	-0.54 (0.31)	-1.16 (0.45)	-0.75 (0.32)
Range	1.8-5	1.6-5	1.8-5
Communication skills			
Mean (<i>SD</i>)	3.94 (0.59)	3.96 (0.60)	4.12 (0.59)
Skewness (error)	-0.02 (0.30)	-0.32 (0.45)	-0.71 (0.32)
Range	2.75-5	2.63-4.88	2.5-5
<i>Assertiveness skills</i> (<i>n</i> = 50) (<i>n</i> = 21) (<i>n</i> = 50)			
Mean (<i>SD</i>)	4.14 (0.86)	3.98 (0.88)	4.34 (0.69)
Skewness (error)	-1.10 (0.34)	-0.69 (0.50)	-1.73 (0.34)
Range	1.67-5	2.33 - 5	2-5
<i>Birth control assertiveness skills</i> (<i>n</i> = 36) (<i>n</i> = 18) (<i>n</i> = 34)			
Mean (<i>SD</i>)	4.83 (0.38)	4.58 (0.77)	4.65 (0.77)
Skewness (error)	-2.29 (0.39)	-2.58 (0.54)	-3.65 (0.40)
Range	3.5-5	2-5	1-5
STI protection assertiveness skills (<i>n</i> = 40) (<i>n</i> = 18) (<i>n</i> = 37)			
Mean (<i>SD</i>)	4.11 (1.26)	4.11 (1.22)	3.86 (1.33)
Skewness (error)	-1.49 (0.37)	-1.36 (0.54)	-1.09 (0.39)
Range	1-5	1-5	1-5

Note. Scales in italics identified for poor reliability.

proportions of the sample elected not to respond to some of these items, such as how often they felt they could talk to a partner about birth control (item 23; 35 responses, 28 missing data), how often they insisted on using birth control (item 24; 34 responses, 29 missing data), how often they felt they could talk to a partner about STI protection (item 25; 38 responses, 25 missing data), and how often they insisted on using STI protection

(item 26; 39 responses, 24 missing data). Likelihood of opting out of these items was influenced by relationship status (with 17/25 single participants opting out), sexual orientation (with 8/9 participants in same-sex relationships opting out of birth control items), and the proportion of participants who had never engaged in sexual intercourse (with 15/18 nonsexually active participants opting out). Responses from participants who elected to answer these items regarding birth control were vastly skewed to the top of the range (range = 3-5), indicating that individuals who felt this question applied to them are already confident in their abilities to engage in these tasks, however the full range was utilized on parallel STI items (range = 1-5).

Scores for behavioral comfort scales (see Table 17) range from a possible 1 (“If you are *very uncomfortable*”) to 4 (“If you are *comfortable*”). Comfort scale responses tended to vary more than behavioral engagement responses, and the full range was utilized on all scales. Participants were least comfortable discussing sexual topics with parents, but somewhat comfortable discussing these topics with friends or partners (frequency with which participants were engaged in such conversations is reported below). Participants were somewhat comfortable being sexually assertive (saying “no”), and primarily satisfied with their current sex life, whatever that may be. They were largely comfortable getting and using birth control, but less so regarding STI protection. Response rates for items about acquiring and using contraceptive and STI protective methods were also lower than the majority of other items and scales, although greater than the items discussed above (items 44-51; average 45 responses, 18 missing data).

In addition to the Behavior Inventory scales, participants reported the frequency

Table 17

Behavioral Comfort Means, Standard Deviations, and Skewness

Scale (Possible range = 1-4)	Pretest (n = 62)	Waitlist (n = 27)	Posttest (n = 56)
<i>Comfort engaging in social activities</i>			
Mean (SD)	3.28 (0.77)	3.39 (0.64)	3.45 (0.66)
Skewness (error)	-1.28 (0.30)	-1.13 (0.45)	-1.68 (0.32)
Range	1-4	2-4	1-4
	(n = 61)	(n = 25)	(n = 55)
<i>Comfort talking with parents about sex, BC, and STI protection</i>			
Mean (SD)	2.12 (1.05)	2.15 (1.18)	2.20 (1.10)
Skewness (error)	0.45 (0.31)	0.45 (0.46)	0.39 (0.32)
Range	1-4	1-4	1-4
	(n = 60)	(n = 26)	(n = 54)
<i>Comfort talking with friends about sex, BC, and STI protection</i>			
Mean (SD)	3.29 (0.81)	3.31 (0.81)	3.58 (0.64)
Skewness (error)	-1.23 (0.31)	-0.86 (0.46)	-1.86 (0.33)
Range	1-4	1.67-4	1-4
	(n = 57)	(n = 24)	(n = 51)
<i>Comfort talking with partner(s) about sex, BC, and STI protection</i>			
Mean (SD)	3.23 (0.85)	3.49 (0.63)	3.36 (0.78)
Skewness (error)	-1.04 (0.32)	-1.28 (0.47)	-1.19 (0.33)
Range	1-4	2-4	1-4
	(n = 59)	(n = 26)	(n = 54)
<i>Comfort being sexually assertive (saying "no")</i>			
Mean (SD)	3.01 (0.85)	3.23 (0.74)	3.19 (0.75)
Skewness (error)	-0.64 (0.31)	-0.65 (0.46)	-0.88 (0.33)
Range	1-4	1.5-4	1-4
	(n = 45)	(n = 21)	(n = 37)
<i>Comfort getting and using BC</i>			
Mean (SD)	3.47 (0.68)	3.68 (0.33)	3.63 (0.58)
Skewness (error)	-1.98 (0.35)	-1.08 (0.50)	-2.90 (0.39)
Range	1-4	2.75-4	1-4
	(n = 45)	(n = 21)	(n = 43)
<i>Comfort getting and using STI protection</i>			
Mean (SD)	3.12 (0.76)	3.63 (0.38)	3.50 (0.66)
Skewness (error)	-1.25 (0.35)	-0.90 (0.50)	-1.93 (0.36)
Range	1-4	2.75-4	1-4
	(n = 60)	(n = 26)	(n = 55)
<i>Satisfaction with current sex life</i>			
Mean (SD)	3.53 (0.87)	3.77 (0.51)	3.69 (0.64)
Skewness (error)	-1.93 (0.31)	-2.26 (0.46)	-1.79 (0.32)
Range	1-4	2-4	2-4

Note. Scales in italics identified for poor reliability.

with which they were engaged in a variety of activities. Responses indicate that the majority of the sample had engaged in sexual intercourse (69.8%, $n = 44$), and about half had had sex in the past month (49.2%, $n = 31$). Of the 31 who reported they had engaged in sex in the past month, the majority (68.8%, $n = 22$) reported having sex 10 or fewer times, 21.8% ($n = 7$) reported having sex 11-20 times, and 9.4% ($n = 3$) reported having sex more than 20 times. Of those participants who were sexually active in the past month, more than one half reported that they had sex at least once in the past month without using any form of STI protection (53.1%, $n = 17$). One in 10 reported they had sex at least once in the past month without using any form of contraception (9.4%, $n = 3$), and two-in-ten indicated this item was not applicable (18.8%, $n = 6$). About two thirds of sexually active participants reported using hormonal birth control methods (62.5%, $n = 20$), and over half reported using condoms or dental dams (56.3%, $n = 18$).

Participants were also asked to indicate how many times they had conversations or discussions about sexual topics with a variety of people during the past month. In conversations with friends (at least once during the past month), the majority of individuals had discussed sex (80.9%, $n = 51$), more than half had discussed birth control (53.9%, $n = 34$) and just under a quarter had discussed STIs (23.8%, $n = 15$).

Conversations with partners were somewhat less frequent. Two thirds had discussed sex (66.7%, $n = 42$), about half had discussed birth control (47.6%, $n = 30$), and a third had discussed STIs (33.3%, $n = 21$). Participants were least likely to have had conversations about these topics with their parents. One in four had discussed sex (26.9%, $n = 17$), one in five birth control (17.5%, $n = 11$), and less than one in 10 STIs (6.3%, $n = 4$).

RQ3.a Impact of the Group on Knowledge, Attitudes, and Behaviors

To evaluate the efficacy of the group, two types of analyses were conducted. Collapsing the waitlist control and initial intervention groups, repeated measures dependent samples *t* tests were employed to determine what changes occurred with regard to knowledge, attitudes, and behaviors between sessions 1 and 4 of the group. Because the number of analyses conducted inflates probability of Type I (false-positive) error, interpretation of results is focused on those that achieved medium or larger effect sizes (defined by Cohen as *d* around .5 or larger, or by partial eta squared values of around .09 or larger). Between-groups 2 x 2 ANOVAs, with group as a between subject variable and time as a repeated measures variable were used to examine differences between the intervention and waitlist control groups on each of the Mathtech measures to determine whether changes may be attributed to group participation rather than time or other factors. As the interaction term is the effect of interest in determining the effectiveness of the group relative to the waitlist control over time, the only *F* statistics reported in this section are the interactions between group membership (waitlist vs. control) and time. Main effects for scales with significant change are reported in Appendix K.

Outcomes indicated that participant knowledge improved significantly between the beginning and end of the intervention, $t(55) = -5.254, p < .001, d = -.702$. It is unclear, based on the results of the ANOVA, how much of this result was due to the group itself rather than simply time, $F(1, 54) = 2.782, p = .101, \eta^2 = .049$). Closer examination of the knowledge inventory at the item level indicates that participant

improvement primarily occurred on items regarding pregnancy odds, specific contraceptive methods (e.g., the pill, natural family planning), and characteristics of particular STIs. Improvement was less pronounced on items regarding national statistics (e.g., number of high school students who are sexually active), puberty and physical development, and the benefits of contraceptive and STI protective methods. Overall, these improvements tend to align with the modules that were formally presented in the group (e.g., pregnancy odds, contraceptive methods, STIs and STI protection). However, even with the improvements seen, large proportions of the sample still missed a selection of items at posttest (see Table 13), indicating that more formal instruction on these topics may be warranted with college aged populations.

Improvement was also observed among participants' knowledge of local resources for reproductive health needs. Prior to the intervention, 84.1% of participants were able to correctly identify local resources, while 15.9% could not. Fifty-four percent of participants listed the USU Student Health and Wellness center as a resource, and 50.8% listed Planned Parenthood. After group participation, 96.4% of participants were able to correctly identify local resources, while 3.6% still did not. After the group, 70.9% listed student health and 80% listed Planned Parenthood, indicating that participation did increase awareness of local reproductive health services.

A variety of attitudes and values appeared to be impacted by the group. A *t* test analysis indicated that significant change occurred on seven of the 14 AVI scales (see Table 18), while ANOVA results indicated that the interaction of group by time was significant for five scales (see Table 19). A brief description of each of the scales with

Table 18

Attitudes and Values Inventory t-Test Results

Scale	<i>t</i>	<i>df</i>	<i>p</i>	<i>d</i>
<i>Understanding of personal sexual response</i>	-4.268	54	<.001	-0.576
<i>Clarity of personal sexual values</i>	-3.814	53	<.001	-0.519
Understanding of emotional needs	-3.161	54	0.003	-0.426
Self-esteem	-3.069	53	0.003	-0.418
<i>Attitude toward sexuality in life</i>	-2.826	48	0.007	-0.404
<i>Attitude toward the importance of birth control</i>	-2.763	54	0.008	-0.373
Satisfaction with personal sexuality	-2.670	53	0.010	-0.363
Understanding of personal social behavior	-1.840	54	0.071	-0.248
<i>Recognition of the importance of the family</i>	-1.729	51	0.090	-0.240
Clarity of long-term goals	-1.555	54	0.126	-0.210
<i>Attitude toward the use of force and pressure in sexual activity</i>	-0.686	54	0.495	-0.093
Attitude toward premarital sex	0.663	54	0.510	0.089
<i>Attitude toward gender roles</i>	-0.534	54	0.595	-0.072
Satisfaction with social relationships	0.090	50	0.928	0.013

Note. Scales in italics identified for poor reliability.

Table 19

Attitudes and Values Inventory ANOVA Results: Summary of Interaction Effects

Scale	<i>F</i>	<i>df</i>	<i>p</i>	η^2
<i>Understanding of personal sexual response</i>	10.196	1, 51	0.002	0.167
<i>Attitude toward sexuality in life</i>	8.262	1, 50	0.006	0.142
Satisfaction with personal sexuality	4.708	1, 51	0.035	0.085
<i>Attitude toward gender roles</i>	4.102	1, 54	0.048	0.071
<i>Recognition of the importance of the family</i>	4.057	1, 52	0.049	0.072
<i>Clarity of personal sexual values</i>	2.368	1, 53	0.13	0.043
Clarity of long-term goals	2.018	1, 54	0.161	0.036
Satisfaction with social relationships	0.754	1, 49	0.39	0.015
<i>Attitude toward the importance of birth control</i>	0.517	1, 54	0.475	0.009
Understanding of personal social behavior	0.505	1, 54	0.48	0.009
Self-esteem	0.261	1, 52	0.612	0.005
Understanding of emotional needs	0.213	1, 54	0.647	0.004
<i>Attitude toward the use of force and pressure in sexual activity</i>	0.103	1, 54	0.75	0.002
Attitude toward premarital sex	0.054	1, 54	0.818	0.001

Note. Scales in italics identified for poor reliability.

significant movement is below. All scales on the AVI not described below demonstrated no significant time or interaction effect.

- *Understanding of personal sexual response*—The first session of the group targets similarities and differences in female and male anatomy and sexual response. Significant movement on this scale was observed through the dependent samples *t* test with a medium effect size, as well as a significant interaction effect (see Figure 3).
- *Clarity of personal sexual values*—Personal values and boundaries regarding sexual relationships are key themes of the intervention and are addressed in all four sessions. Significant movement on this scale was observed between pre- and postintervention assessment with a medium effect size. However, ANOVA analysis did not find a significant interaction effect.

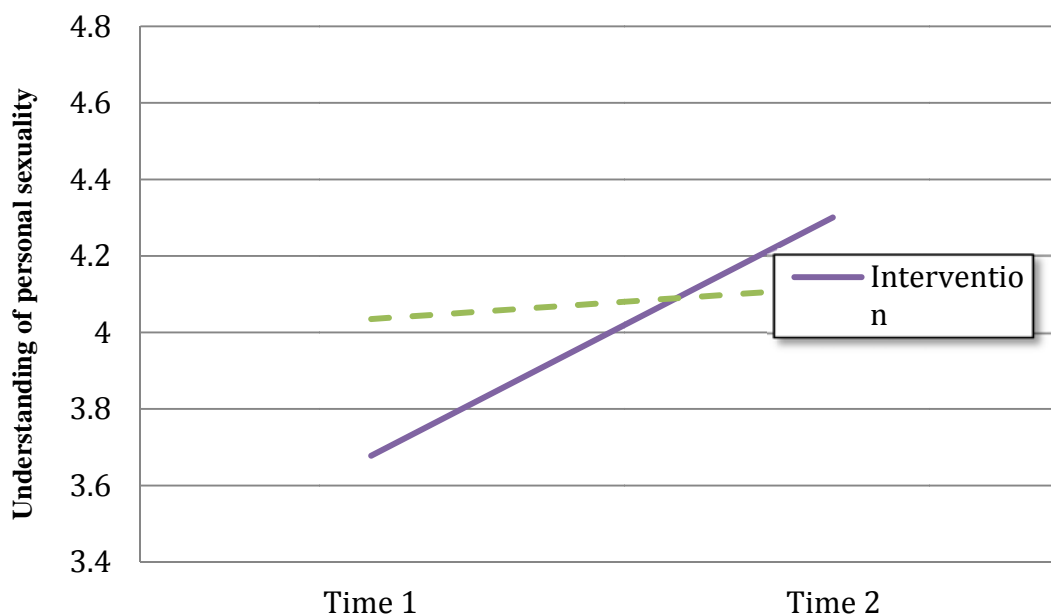


Figure 3. Understanding of personal sexuality interaction effect.

- *Understanding of emotional needs*—Emotional aspects of sexuality were addressed primarily in relation to values and boundaries. Participants indicated through feedback that they were interested in further or more explicit exploration of emotional components of sexuality. Although this was not a formally presented topic in the group, significant change on this scale was observed over time, though a significant interaction effect was not supported.
- *Self-esteem*—Self-esteem was explored indirectly through the group. It is conceptualized that many aspects of the group could feasibly influence this scale, including exploration (and debunking) of myths and stereotypes, presentation of factual information, and group discussions which presented opportunities for personalization of learning and normalization of questions and discomfort. A significant effect for time emerged in analysis, although no interaction was found.
- *Attitude toward sexuality in life*—Having a positive attitude toward the role of sexuality in one's life could be argued to be an important foundation of healthy sexuality, and therefore one of the primary goals of the group. Significant change over time as well as a significant interaction effect was found for this scale despite its questionable reliability (see Figure 4). Medium to large effect sizes for this scale indicate that the intervention was a powerful influence on this construct.

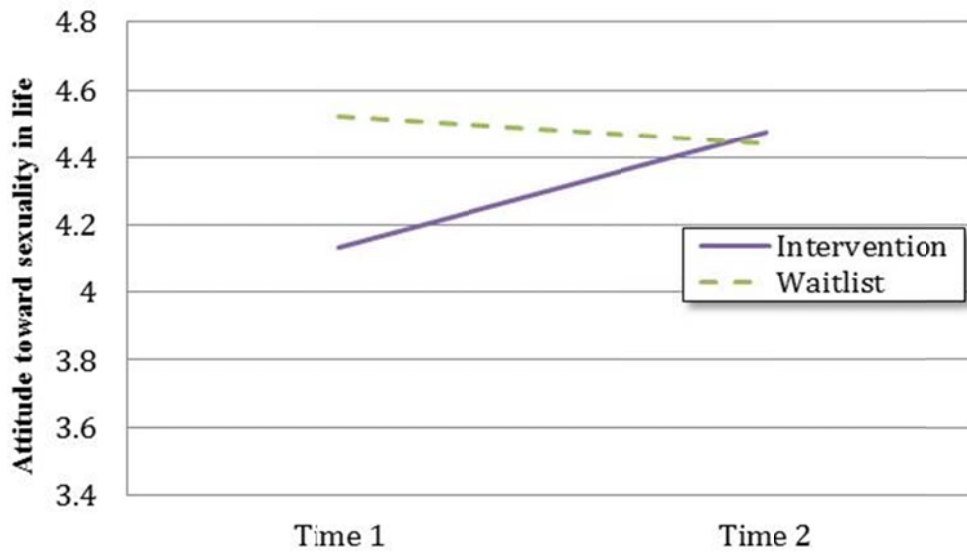


Figure 4. Attitude toward sexuality in life interaction effect.

- *Attitude toward the importance of birth control*—This scale demonstrated questionable reliability in initial analyses due to a restricted range in which the majority of participants viewed birth control as extremely important. Despite these high scores prior to intervention, significant improvement on this scale was still observed over time, although an interaction effect was not supported.
- *Satisfaction with personal sexuality*—One of the repeated messages of the group was that there is no “right” or “wrong” approach to one’s personal sexuality, so long as decisions are based on factual information (rather than myths or stereotypes) and genuine consent is obtained from all involved parties. This approach is congruent with a variety of personal sexualities from the most promiscuous to most conservative, and emphasizes personal “fit” of values and behaviors over social/media messages or “rules.” A small-to-medium effect was found for this scale over time, as well as a large interaction

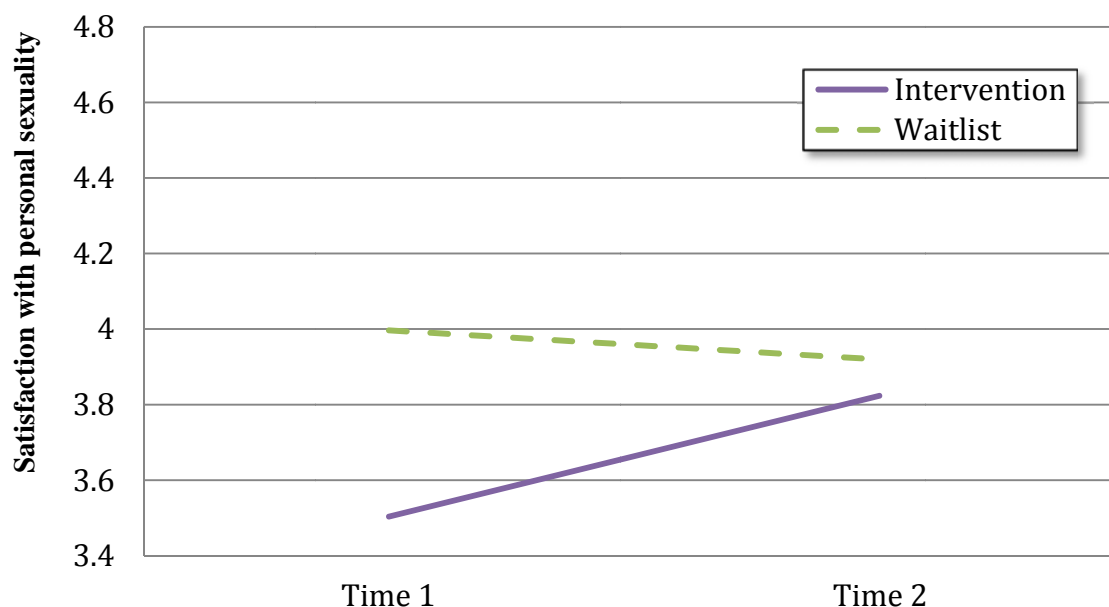


Figure 5. Satisfaction with personal sexuality interaction effect.

- Attitude toward gender roles*—Gender role stereotypes and expectations were explored in all sessions of the group. Group leaders were also intentional about presenting information in gender-neutral ways whenever possible, and strove for inclusivity of all sexual orientations and gender expressions. A significant effect for time was not observed, though a significant interaction was found (see Figure 6).
- Recognition of the importance of the family*—Discussions of family were primarily incidental in the group, with the exception of discussing sexuality education histories and familial attitudes about sexuality. Nonetheless, a small but significant interaction effect was observed (no significance for time; see Figure 7).

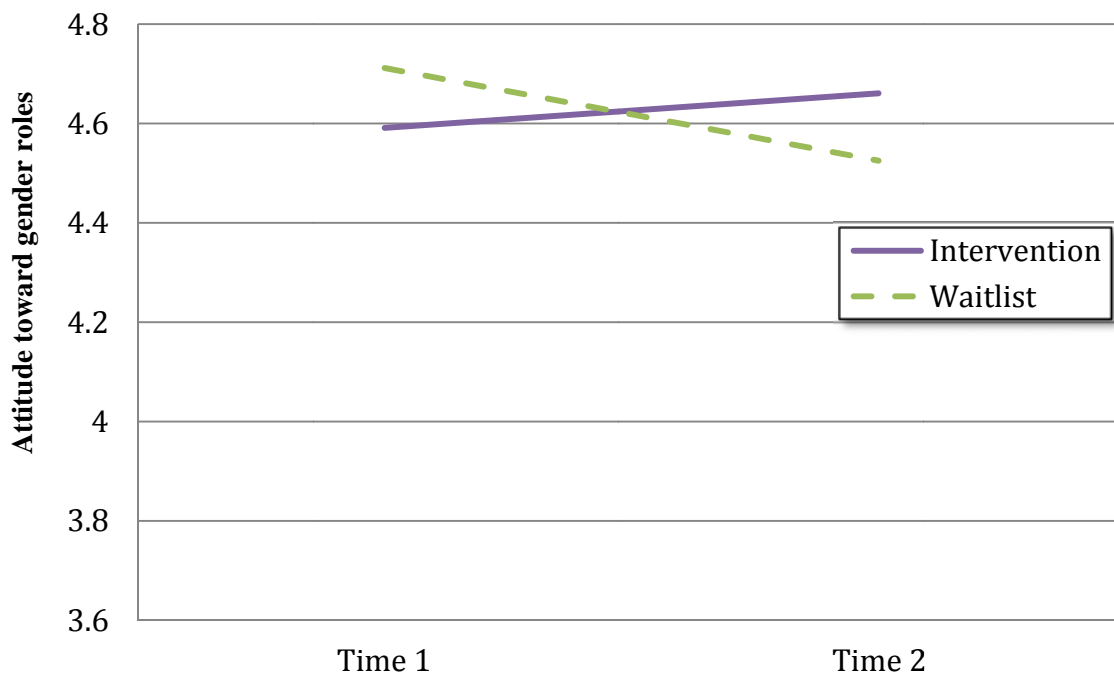


Figure 6. Attitude toward gender roles interaction effect.

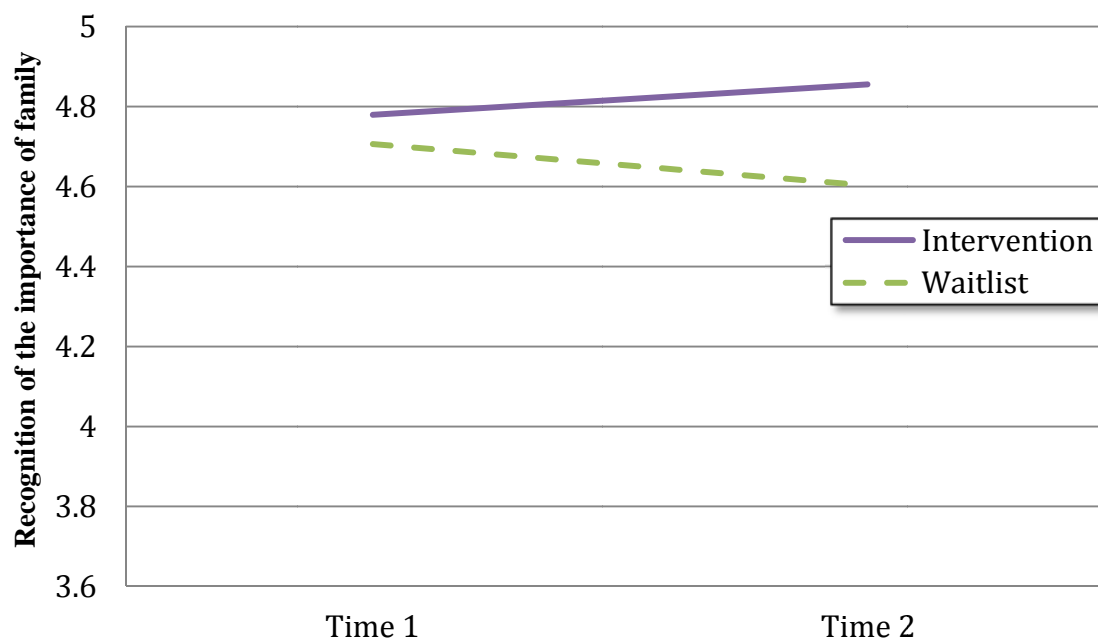


Figure 7. Recognition of the importance of the family interaction effect.

Fewer significant changes were observed in behavior than in knowledge, attitudes and values (see Tables 20 and 21). A significant difference between pre- and post-intervention scores was found on the Assertiveness scale, but no significant interaction was supported. Inversely, a significant interaction was found for birth control assertiveness skills, but no time effect (see Figure 8). Both of these scales demonstrated questionable reliability in initial analyses, and birth control assertiveness in particular demonstrated a strong ceiling effect. However, asserting one's sexual boundaries and desires, including safer sex preferences, was a skill that was emphasized and practiced in multiple sessions of the group.

Table 20

Behavior Inventory t-Test Results

Scale	<i>t</i>	<i>df</i>	<i>p</i>	<i>d</i>
<i>Assertiveness skills</i>	-2.230	42	0.031	-0.340
Communication skills	-1.846	53	0.070	-0.251
Comfort talking with parents about sex, birth control, and STI protection	-1.672	50	0.101	-0.038
<i>Social decision-making skills</i>	-1.637	53	0.107	-0.223
<i>Comfort getting and using birth control</i>	-1.637	53	0.107	-0.166
Comfort engaging in social activities	-1.496	53	0.141	-0.204
<i>Comfort being sexually assertive (saying "no")</i>	-1.477	51	0.146	-0.234
Comfort with current sex life as-is	-1.477	51	0.146	-0.205
STI protection assertiveness skills	1.442	32	0.159	0.251
Comfort talking with partners about sex, birth control, and STI protection	-1.005	33	0.322	-0.252
Comfort talking with friends about sex, birth control, and STI protection	-0.907	29	0.372	-0.282
<i>Sexual decision-making skills</i>	-0.849	51	0.400	-0.118
<i>Comfort getting and using STI protection</i>	-0.849	51	0.400	-0.172
<i>Birth control assertiveness skills</i>	0.338	28	0.738	0.063

Note. Scales in italics identified for poor reliability.

Table 21

Behavior Inventory ANOVA Results

Scale	<i>F</i>	<i>df</i>	<i>p</i>	η^2
<i>Birth control assertiveness skills</i>	4.543	1, 28	0.042	.140
<i>Assertiveness skills</i>	3.477	1, 41	0.069	.078
<i>Comfort being sexually assertive (saying “no”)</i>	1.392	1, 49	0.244	.028
Comfort engaging in social activities	1.237	1, 52	0.271	0.023
Comfort talking with partners about sex, birth control, and STI protection	0.934	1, 45	0.339	0.02
<i>Comfort getting and using birth control</i>	0.141	1, 31	0.71	0.005
Comfort with current sex life as-is	0.125	1, 49	0.725	0.003
Comfort talking with parents about sex, birth control, and STI protection	0.106	1, 49	0.746	0.002
Communication skills	0.101	1, 52	0.751	0.002
Comfort talking with friends about sex, birth control, and STI protection	0.067	1, 50	0.797	0.001
<i>Social decision-making skills</i>	0.047	1, 52	0.83	0.001
STI protection assertiveness skills	0.046	1, 31	0.832	0.001
<i>Comfort getting and using STI protection</i>	0.001	1, 34	0.982	<.001
<i>Sexual decision-making skills</i>	0.000	1, 50	0.991	<.001

Note. Scales in italics identified for poor reliability.

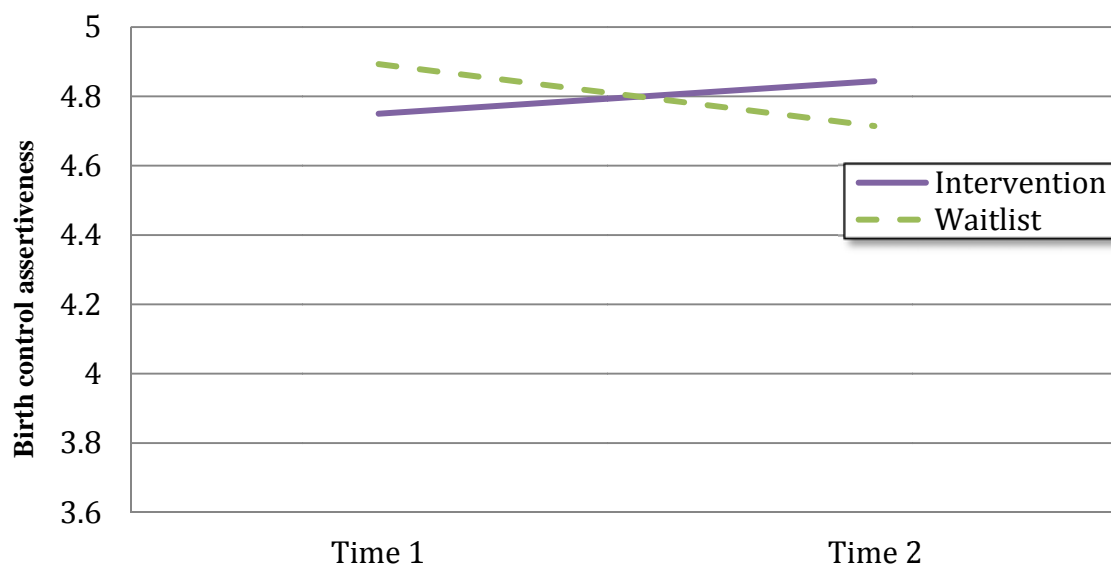


Figure 8. Birth control assertiveness interaction effect.

Overwhelmingly prior research indicates that behavior is more difficult to modify than other constructs (such as knowledge and attitudes), so these limited findings should not be surprising. Furthermore, the pretest/posttest interval of only two weeks is likely not large enough to detect meaningful change in behavior. However, consent was obtained from participants to be contacted an additional time six months following the completion of the group for a final follow-up. It is hoped that more significant and lasting behavioral change may be observed at the 6-month follow-up.

RQ3.b Group Comparison to Prior Sexuality Education

In addition to changes in knowledge, attitudes and values, and behavior, participant feedback about the designed intervention was closely evaluated. Participants completed the Program Feature/Program Outcome questionnaire following the completion of the group, and results were compared to their evaluations of prior sexuality education experiences.

Participants rated the present group more highly than their prior experiences with regard to teacher/leader characteristics, $t(47) = -6.757, p < .001, d = -.975$, perceived influence on understanding, $t(53) = -15.755, p < .001, d = -2.144$, and perceived influence on ability, $t(51) = -13.194, p < .001, d = -1.829$. It is likely that these results are inflated by the recency of group participation and loyalty to group leaders; however they also suggest that there were aspects of the present group that participants found to be more effective and satisfactory than their prior experiences.

Participants also rated the formality with which they felt a variety of topics were

presented in the group (see Table 22). Overall, participants felt that topics were presented more formally in the present group than in their prior experiences (see Table 11). This was particularly true for topics that were not addressed historically for many participants,

Table 22

Formality with Which Specific Topics Were Covered in the Present Group

Topic	Formally covered		Informally covered		Not at all covered		Don't know	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Advantages of the various contraceptive methods.	98.2	55	-		-		1.8	1
Anatomy and physiology.	98.2	55	-		-		1.8	1
Avoiding unwanted sexual experiences.	98.2	55	-		-		1.8	1
Common myths concerning sexuality.	96.4	54	1.8	1	-		1.8	1
Sexually transmitted infections.	96.4	54	1.8	1	-		1.8	1
The effectiveness of the various contraceptive methods.	96.4	54	-		-		3.6	2
Improving communication skills with peers.	94.6	53	1.8	1	1.8	1	1.8	1
Disadvantages of the various contraceptive methods.	91.1	51	7.1	4	-		1.8	1
The probability of becoming pregnant.	83.9	47	12.5	7	-		3.6	2
Improving decision-making skills.	78.6	44	8.9	5	3.6	2	9.0	5
Peer pressure and sexual behavior.	75.0	42	17.9	10	1.8	1	5.4	3
The range of sexual behaviors.	75.0	42	19.6	11	3.6	2	1.8	1
Students' feelings about sexual activity.	71.4	40	25.0	14	3.6	2	-	
Improving problem-solving skills.	69.6	39	17.9	10	5.4	3	7.1	4
Students' attitudes about sexual activity.	69.6	39	28.6	16	1.8	1	-	
Students' attitudes about sex roles.	66.1	37	26.8	15	5.4	3	1.8	1
Biological aspects of human reproduction.	64.3	36	25.0	14	7.1	4	1.8	1
Students' feelings about sex roles.	62.5	35	26.8	15	7.1	4	3.6	2
The relationship between how one feels about one's self and one's behavior.	60.7	34	30.4	17	7.1	4	1.8	1
Human sexuality as an aspect of one's total personality.	53.6	30	35.7	20	3.6	2	5.4	3
Improving communication skills with parents.	32.1	18	41.1	23	21.4	12	5.4	3
Adolescent pregnancy	26.8	15	42.9	24	14.3	8	14.3	8
The social needs during adolescence.	26.8	15	39.3	22	21.4	12	12.5	7
The emotional needs during adolescence.	25.0	14	37.5	21	23.2	13	14.3	8

including contraceptive methods (and their pros and cons), communication, intrapersonal aspects of sexuality (e.g., relation to feelings about self, sexuality as one aspect of personality), and common myths about many of these topics. Although most responses for any given topic tended to cluster together, some variety in responses is observed. This may be influenced by two factors. First, although participation rates were high (71.4%, $n = 40$, attended all four sessions), some participants were absent for some sessions, in which case they may have missed formally presented information (19.6%, $n = 11$, attended three sessions; 8.9%, $n = 5$, attended two sessions; no participants attended fewer than two sessions). Additionally, each group was shaped by the combination of leaders and participants, and group discussions varied from group to group resulting in some groups extending discussions to additional domains while others may never have addressed these topics (e.g., communication with parents).

Finally, participants were asked to rate their satisfaction with the ways in which information was presented in the group, as well as their satisfaction with their sexual knowledge after completion of the group. Satisfaction was rated on a scale from very dissatisfied (1) to very satisfied (7). The mean score for satisfaction with group presentation was 6.7, and for current knowledge was 6.2. These ratings were compared to pre-intervention ratings of satisfaction with the way(s) in which they found out most of what they knew about things having to do with sex (3.9) and their current knowledge about things having to do with sex (5.2). A *t*-test analysis indicated that participants were significantly more satisfied with their learning in the group than prior learning, $t(55) = -1.573$, $p < .001$, $d = -1.546$, and also significantly more satisfied with their sexual

knowledge following the group, $t(55) = -5.040, p < .001, d = -.674$.

In addition to these formal assessments, participants were invited to share their feedback about the group on multiple occasions. At the end of each session, participants were asked to complete an anonymous feedback form outlining what they liked most and least about the session, any remaining questions they had about the topic, and any questions that they had about the planned topic for the following session. Feedback about the group overall was also collected through responses to an open-ended question on the final online survey. Feedback was overwhelmingly positive, with most participants listing the things that they enjoyed most about the group and many suggestions for expanding the topics covered in the group. The few criticisms offered tended to focus on group dynamics (e.g., “felt like the only sexually active woman in group,” “group wasn’t as open as I would have liked,” “I think some messages were conveyed within the group, by other members of the group, that were not intended to be communicated by Brenna”) or structure (e.g., “ended with such a downer topic,” “felt rushed, not enough time”).

Most participants reported that they liked the structure of the group. They appreciated the male-female co-leader pairs, and felt that facilitation encouraged discussion and questioning. Participants listed the comfortable atmosphere, openness, and diversity of group members as other favorite features. Many individuals indicated that discussing questions among the group and hearing the experiences of others facilitated their learning and confidence. Structural suggestions included allowing more time for these discussions, more opportunities to share personal experiences, and the incorporation of name tags to accelerate group cohesion.

Many participants wrote about their appreciation for the broad scope of topics addressed through the group. Participants often listed their favorite sessions or topics in their feedback, including the ongoing emphasis on communication, handouts and discussions regarding sexual myths, STI handouts, and the safer-sex kit demonstration. However, this list was dwarfed by the numerous suggestions of additional topics that could be addressed in such a group. These suggestions are listed below.

- Effective communication regarding tense subjects, baggage
- How to overcome societal roles and pressures
- Pornography
- Masturbation, healthy sexuality without a partner
- How sex changes with age
- How to increase passion in relationships
- Sexual confidence and self-image
- What to expect from your first sexual experience
- What to expect from an annual health exam
- More focus on emotional components of sex and sexuality
- Alternative sexual expressions (e.g., phone sex, cybersex, nonintercourse sex)
- More LGBTQ information, especially regarding transgender sexuality

Participants seemed to be aware that the current length and structure of the group would not provide enough time to address these recommendations (e.g., more discussion, more depth, more topics). Many participants indicated that they wished for more time or more sessions (e.g., “more time to process and think,” “would have attended more

sessions,” “wish it didn’t have to end!”), and this was one of the few recurring criticisms of the group. Some additional examples of participant feedback, in their own words, are included below.

“I just really liked how the group leaders posed questions and then just let everyone discuss. We got through all the material with gentle nudges in the right direction, but we were still able to ask questions that we had and explore other areas other than what was perhaps the original lesson plan.”

“I thought it was great! I would have been willing to attend more sessions. It seems like we were often pressed for time. In fact, many of us chose to stay after on the final session in order to have questions answered.”

“More time!! We easily could have spent two more meetings discussing other topics and other questions that came up (masturbation, LGBT community/support, etc.).”

“That was super fun! I feel that I am a more responsible, capable, and relatable individual now (in many respects, but of course specifically in relation to sex) thanks to this program!!!”

CHAPTER V

DISCUSSION

The primary goals of this study were to assess what aspects of healthy sexuality were present among typical young adults, and to evaluate the effects of a psychoeducational group designed to enhance healthy sexuality. Healthy sexuality is comprised of many components, including accurate knowledge, positive attitudes, and behavioral self-efficacy with regard to personal sexuality and sexual relationships. This conceptualization lends itself to use with the Information-Motivation-Behavioral Skills model (W. A. Fisher et al., 2003), a model of health behavior change that examines the interaction of these three constructs. An intervention was designed with the accessible population in mind, and aspects of participant knowledge, attitudes and behaviors were assessed before and after the four session psychoeducational discussion group designed for this project. Examination of these data illustrated the wide variety of sexuality education experiences that young adults have had, as demonstrated by the range in their knowledge and attitudes. Post-intervention outcomes demonstrated that the designed group was effective in improving knowledge accuracy and increasing positive attitudes. Participant engagement and feedback indicated that the groups were well liked and effective in achieving these goals.

Because of the large amount of data collected in the service of this project, many interesting trends and findings emerged. First, the sexuality education histories of participants are summarized, including family and school-based sources and participant preferences/recommendations. Next, each of the primary domains examined in the study

(knowledge, attitudes, and behaviors) are discussed in terms of pre-intervention levels and change as a result of the group. This is followed by a summary of participant evaluations of the groups, including comparisons to school-based experiences and open-ended participant responses. Finally, strengths and weaknesses of the present study and recommendations for further research are outlined.

Sexuality Education Histories

Young adults receive sexual information from a wide variety of sources, including (for example) families, peers, schools, media, and independent research (Borzekowski & Rickert, 2001; Kaiser Family Foundation, 2003). Participants in the present study overwhelmingly indicated that they would prefer that their parents were their primary source of information for most topics, but this was largely not the case. It is likely that this is influenced by discomfort among parents and adolescents regarding discussion of sexual topics with one another (Fox & Inazu, 1980; Hutchinson & Cooney, 1998). Depending on the topic, primary sources of information included peers (usually female friends), teachers, religious leaders, and reading independently. When parents were sources of information, mothers were more often involved than fathers, consistent with previous research (Chilman, 1990). When asked if they would handle their children's sexuality education in the same way as their own, most participants said no. Participants who did receive information from parents were more likely to say they would address their own children's education in same way. Participants with children indicated that they hoped the group would help them better teach their children about sex and sexual

relationships. Some participants suggested offering a similar group for parents to help them discover ways to talk to their kids.

Sexual knowledge, attitudes and behaviors may also be influenced by parental and peer attitudes (Schalet, 2004). Within the IMB model, this is most likely to impact “social motivation,” or perceived social support for engaging in particular health behaviors (W. A. Fisher et al., 2003). In the present study, participant responses indicated that parental and peer attitudes were largely conservative regarding sexual relationships. This potentially contributes to a culture in which people cannot ask for information about sex/sexuality. In the service of increasing healthy sexuality, it is important to destigmatize open communication about sex (Chilman, 1990), and this type of program may be one method for doing so. It is important to note that conservative attitudes about sex and sexuality need not inherently present a barrier to discussing sexual information (e.g., providing factual information, facilitating skill-development for use in future relationships such as marriage; Regnerus, 2005; Weaver et al., 2005).

Information provided by participants illustrated that school-based experiences vary widely for young adults. While some participants indicated that they had positive experiences with school-based sexuality education (e.g., teacher characteristics, increased understanding and ability), many did not. Consistent with previous research, topics covered in school-based sexuality education tended to focus on biological processes (e.g., anatomy, reproduction) and risks (e.g., STIs, unwanted experiences), but not prevention (e.g., contraception, condom use, STI testing and treatment), emotional/relational aspects, personal aspects (e.g., student values and attitudes), or LGBTQ/nontraditional

relationships (Kempner, 2001, as cited in Weiser & Miller, 2010; Lindberg et al., 2006). Because of the importance of information as an initial prerequisite to behavior change, as stated by the IMB model, the implications of selective sexuality education curricula must be further examined.

In summary, although some young adults receive thorough sexuality education, many do not (Lindberg et al., 2006). As recommended by others, it is important that parents and schools ascertain that their children and students' needs are being met by sexuality education programs, and that these programs are providing accurate information and contributing to skill development, such as communication and safer sex practices (Kirby et al., 1994; Landry et al., 1999; Rosenbaum, 2009; Weiser & Miller, 2010). The present program could be easily adapted for many settings (e.g., classroom, after-school, church/community groups, residence halls) in order to increase resources for students who did not receive the education they desire or feel they need.

Knowledge

As may be expected based on the wide variety of sexuality education experiences described above, participant knowledge accuracy also ranged widely. On a measure designed for usage with high school students (Synovitz et al., 2002), participants' prior knowledge accuracy ranged from 45% to 95%. Many of the items on the knowledge test concern what may be considered very basic sexual facts (Kaiser Family Foundation, 2003), yet were unknown to large proportions of the current sample. For example, knowledge regarding pregnancy risk among heterosexual couples was questionable, a

concerning finding as the majority of the sample identified as exclusively or mostly other-sex attracted. This indicates that even though most school-based sexuality education programs focus on heterosexual relationships exclusively (Kempner, 2001, as cited in Weiser & Miller, 2010), students are not receiving/retaining accurate information about pregnancy risk.

Another concerning finding to emerge in analyses was that participant satisfaction with knowledge about sexual matters was completely unrelated to their knowledge accuracy. In other words, while some students were satisfied with accurate knowledge and others were unsatisfied and lacking information, it was just as likely that students with inaccurate knowledge were satisfied and students with accurate knowledge felt they did not know enough. This finding implies that individuals may believe that they are making well-informed decisions when in fact they are operating under false assumptions. Without accurate information, these individuals may be more likely to engage in sexually risky behaviors without awareness of the actual risk inherent, or may avoid use of safer sex practices if they have been misinformed that these methods are ineffective. These individuals would also be unlikely to seek corrective (accurate) information and may contribute to misinformation amongst their peers and partners, thereby perpetuating inaccurate knowledge and potentially impacting motivational factors.

Following the intervention, knowledge scores ranged from 59% to 95%, a significant improvement from pretest knowledge scores ranging from 45% to 95%. Unsurprisingly, answers to items that aligned most closely with material presented in the group were most likely to improve between time one and time two. Many participants

still answered a variety of questions incorrectly, particularly questions relating to rates of behavior among adolescents and young adults (e.g., number of high school students who have had sexual intercourse, number of women under age 20 who become pregnant; Kaiser Family Foundation, 2003). Participants tended to overestimate the number of sexually active high schoolers, and underestimate pregnancy rates for young women. In part, this is influenced by the inherent difficulty in assessing these rates. However, it may be useful to provide this information to young people, who may adjust their behavior or social-comparisons as a result.

It may be argued that particular aspects of sexual knowledge, such as those that “do not apply” to the individual in question, matter “less” to healthy sexuality than those that have personal application. However, recognition of the social motivational component of the IMB model may support the notion that comprehensive sexuality education has an impact on not only individuals, but also communities. Providing accurate, comprehensive information to large groups of individuals may increase social support for engagement in sexual health promoting behaviors, such as condom use, STI testing and treatment, and clear communication about sex. Such a cultural shift may impact communities at both micro (e.g., interpersonal relationships) and macro (e.g., politics and policy) levels. For instance, if more people were aware that up to one in three young women will become pregnant by age 20 (a frequently cited but difficult to confirm statistic), this may influence attitudes about national need for comprehensive sexuality education and access to contraceptive and reproductive health services among young people, as well as attitudes towards young and unwed mothers/parents. In other words,

knowledge of matters that do not appear to have personal application may most directly influence healthy sexuality by way of motivation.

Knowledge of local resources also improved from time one to time two. Although the majority of participants were currently enrolled at the University, they did not all list University Student Health and Wellness as a potential resource prior to the intervention (this increased from 54% to 71%), nor did as many participants list Planned Parenthood as a resource prior to the intervention (from 51% to 80%). This highlights the importance of colleges and universities providing explicit information to students about campus and local reproductive health resources.

Overall, these findings support previous assertions that college students still have gaps in their sexual knowledge (Synovitz et al., 2002). Participants in the present study responded well to having this material presented and discussed, as illustrated by changes on the knowledge test as well as self-reported satisfaction. Programs such as the group developed here may be of value to higher education establishments in helping young adults fill the gaps in their sexual knowledge.

Attitudes

Attitudes and values regarding sexuality tended to be positive among the young adults who elected to participate in the study. Attitudes tended to become more positive over time, although these changes were significant on only about half of the scales. Scales that improved significantly from time one to time two included Clarity of Personal Sexual Values, Understanding of Personal Sexual Response, Attitudes toward Sexuality

in Life, and Satisfaction with Personal Sexuality. These scales align closely with many of the primary goals of the designed curriculum based on characteristics of healthy sexuality described in the existing literature (Edwards & Coleman, 2004). It is likely that the relatively positive attitudes among the majority of participants were influenced by self-selection bias among those who were interested in the present group, but is an uplifting finding nonetheless.

The only domain in which attitudes were comparably less positive at both time periods (no significant change) was attitudes towards premarital sex. These attitudes are likely strongly influenced by the primarily LDS upbringing among the majority of participants (Holman & Harding, 1996; Regnerus, 2005). It would be interesting to compare the attitudes of participants in this study with attitudes of similar populations in different regions of the US. However, conservative religious beliefs are not unique to Utah, and disapproval of premarital sex is promoted in many school-based sexuality education programs (especially abstinence-only programs) nationwide.

Behaviors

Participants were largely satisfied with their current sex lives, whatever they may be. Participants' levels of sexual activity were comparable to national statistics, with the majority being sexually active (University of Minnesota, 2007). About two thirds of sexually active participants reported using hormonal birth control, and about half reported using condoms or dental dams, slightly higher than rates found in other studies of adolescents and LDS young adults (Goldscheider & Mosher, 1991; Kershaw et al., 2003).

While only one in 10 of sexually active (presumably heterosexual) participants reported having sex in the past month without using contraceptive methods, over half (of all sexually active participants) reported that they had sex at least once in the past month without using any form of STI protection. Because of the short term nature of the present study, lasting changes in behavior could not be measured, but it is hoped that the information and communication skills emphasized in the group may increase rates of safer sex practices among participants.

Sexual communication, including sexual assertiveness and negotiation of sexual behaviors and safer-sex practices, are important aspects of healthy sexuality (Greene & Faulkner, 2005; Morokoff et al., 1997). Participants were fairly confident in their ability to engage with particular behavioral skills, and were mostly comfortable using skills. These ratings tended to improve over time, although not significantly on most scales. Participants were more confident in their social decision-making skills than their sexual decision-making skill, and more confident in their assertiveness skills than their overall communication skills. That is, they felt more comfortable asserting their boundaries (e.g., requiring safer sex practices, saying “no” to unwanted experiences) than they did about discussing sex in general. This supports previous research indicating that even partners in long-term relationships tend to communicate somewhat about their sexual preferences, but do not tell their partners everything (Byers, 2011). With regard to safer sex practices, participants were very confident in their birth control assertiveness and most comfortable getting and using birth control, but less so regarding STI protection assertiveness and getting and using STI protection. Assertiveness and Birth Control Assertiveness were the

only scales to improve significantly as a result of the intervention.

Participants were asked about their comfort discussing sexual topics (sex in general, birth control, and STI protection) with a variety of people in their lives (friends, partners, and parents). Participants were most comfortable discussing sexual topics with friends, and slightly less comfortable with partners. In all cases, participants were most likely to discuss sex in general, somewhat less likely to discuss birth control, and least likely to discuss STIs or STI protection in these conversations. Participants discussed sex and birth control more with friends, but STIs more with partners. Participants were most uncomfortable (on all the scales) discussing these topics with parents. Discussing sex with family/parents was not a focus of the group, and most of the participants in the current study no longer resided with family or would be expected to have these conversations with parents. However, this skill could be incorporated into the present group if desired (e.g., for use with younger participants or families).

Group Reception, Evaluation, and Recommendations

Overall, participants rated the group very highly. Participants gave more positive ratings of group leaders than prior sexuality educators, and indicated that they felt a greater sense of understanding and ability as a result of the current group compared to ratings of past experiences. This is undoubtedly biased by the recency of the group as well as the relationship between participants and the primary researcher and group leaders. However, establishment of such rapport between students and sexuality educators may be an important factor in maintaining student engagement, thereby

increasing opportunities for learning.

Participants were particularly engaged with discussion. In fact, participants elected to complete posttest surveys online rather than during group in order to spend more time in discussion. Many groups chose to use this time to continue exploring topics previously addressed in the group, while other groups introduced additional topics for discussion during this time (e.g., pornography, masturbation, communication within families, casual vs. committed relationships). Participants also shared feedback with each other and group leaders during this time about what they valued most about the group, and what they would have changed about it.

Participants had many recommendations for improving the group and expanding its impact, many of which have been made in other studies of young adults' perceptions of sexuality education (von Sadvoszky et al., 2006). They suggested a variety of additional topics that they wished could have been covered in the group. In addition to further topics, participants also advocated for more sessions and more opportunities for personal sharing. They also suggested additional settings for the groups, such as schools, after-school groups with students and/or parents, freshman orientation seminars, and campus organizations. Many participants expressed interest in developing a less formal, similarly focused discussion-based "sex positive" group on campus.

Project Strengths

The current project could not have been successful without the interest, motivation, and loyalty demonstrated by students and community members on campus.

Participants in the study remained engaged over time, with high rates of group attendance and minimal attrition (only two individuals who began the groups did not complete them). This project required a great deal of time from each participant, including a relatively lengthy set of online measures to complete outside of groups at multiple time points as well as up to 6 hours of group attendance. Participants demonstrated strong support for the project on campus, helping with word-of-mouth recruitment for the study and attending poster sessions displaying preliminary results. They also established warm rapport with group leaders and fellow group members, contributing to a safe and enjoyable learning environment for everyone involved.

Participant diversity in sexual orientation was another strength of the groups. The present study had a notable proportion of LGBTQ-identified participants compared to most studies (30% of current sample vs. population estimates of < 10%). The oversampling of LGBTQ-identified participants was likely influenced by a variety of factors, including the primary researcher's involvement in the campus community, higher levels of sex positivity among LGBTQ communities, and the absence of applicable school-based sexuality education programming for LGBTQ-identified youth. LGBTQ individuals are more likely to have their needs overlooked in school-based sexuality education programs, so this may have been a novel experience in receiving inclusive information. This diversity of perspectives allowed for discussion of variety of sexual relationships, gender dynamics, and life experiences, and likely proved valuable for both LGBTQ and straight participants. Having open conversations about LGBTQ relationships and sexual health needs also likely contributed to the knowledge of heterosexually

identified participants and may increase tolerance, acceptance, and support for LGBTQ individuals, couples, and rights.

Participants also had diverse sexual values and experiences, which further enriched the groups. Conversations about sexual activity versus abstinence are often contentious and judgment laden. Through the structure and diversity of the group, sexually active and abstinent participants were all invited to discuss different attitudes and values in a nonconfrontational, nonjudgmental environment, allowing for more open-minded exposure to different perspectives.

The structure of the group worked effectively, and provided a strong framework for engaging in taboo conversations. This was facilitated by skilled and dedicated group leaders who grasped material, established rapport with participants, and were committed to their own learning across the project. Participants reported that they liked the group format and topics, and appreciated the handouts. Some aspects were hit-or-miss (e.g., ice-breakers, role-plays) with some participants enjoying these very much and others disliking them. However, the flexibility built into group modules allowed participants and leaders the freedom to modify these activities as needed in order to make them most useful to each unique group.

Finally, because this study conceptualized healthy sexuality as a conglomerate of many constructs rather than a single construct of its own, a wide variety of assessments were employed. This allowed for examination of a variety of outcomes, including sexual knowledge, attitudes and values, and behaviors as well as sexuality education history, parental/peer influences, and open-ended, qualitative feedback from participants. The

data collected provide a glimpse into the variety of sexuality education experiences of young adults and their outcomes, as well as a clear evaluation of the group curriculum designed for the study and its outcomes.

Project Weaknesses

The nature of the present project undoubtedly contributed to a self-selection bias among participants. Advertisements on campus consisted of flyers in academic buildings and housing, as well as announcements in psychology courses. Although wider advertisement was desired, the project was not considered to be of “widespread, general interest to most students” and was, therefore, not advertised on the university email login page. As a result, advertisements for the project may not have had as wide a reach as desired. Interested persons met with the primary investigator for more information before signing up. Participants listed a variety of reasons they were interested including the general desire to learn more, applications in personal relationships (e.g., dating, engagement, marriages), concerns about sexuality education in the US, and ideas for their own children’s sexuality education. In other words, many of the participants in this study already had a strong interest in learning more about sex and sexuality. Participants themselves indicated that they wished this type of program was more available to students on campus who were less confident, curious, or outgoing and that groups would have included participants with lower levels of pre-intervention knowledge.

Although the present sample was diverse in terms of sexual orientation, sexual experience, current relationship status, and age, the sample did not have wide

ethnic/racial diversity. Additionally, the vast majority of the sample had been raised as members of the LDS church. Further exploration of the influence of the present group among populations with more diverse demographic and religious backgrounds would increase generalizability and likely contribute to making the group more widely applicable.

Because of the time limitations of the current group, such as 90-minute periods and a set limit of four sessions per group, many conversations had to be cut short, and many topics were never formally addressed. Should this intervention be used in a manner less formal than a research study, it is recommended that leaders consider the perceived needs and formal requests of participants in offering further time for discussion of topics, exploration of questions, and perhaps additional sessions to cover further material (e.g., emotional components, non-traditional relationships, LGBTQ relationships more specifically, etc.).

The present study examined many aspects of healthy sexuality using a variety of measures. This was a time-consuming requirement for participants (and the researcher), but resulted in a great amount of data for analysis. However, in examining so many scales a larger sample size would have increased power, strengthening our findings. Further evaluations of such programs should seek to increase sample size when possible, or focus research questions to fewer constructs/domains.

Because of the 2-week nature of the test/retest window, it was not possible to examine changes in rates of behavior. However, participants agreed to a third and final completion of the Mathtech Questionnaires six months after completion of their group. It

is hoped that analysis of this six-month data will illuminate any behavioral changes as a result of participation in addition to long-term effects on knowledge and attitudes.

Directions for Further Exploration

The present study collected a large amount of data. Additional questions that may be examined in the current data set include the following.

- Are there significant differences in any of the domains between older and younger students (e.g., > 24 vs. < 24)? In particular, are there differences in sexuality education experiences that may be influenced by the “era” in which participants were in school?
- Are there significant differences in any of the domains between male and female participants? In particular, are there differences in contraceptive knowledge, attitudes, and behaviors between females and males?
- Are there significant differences in any of the domains between LGBTQ and heterosexual participants? In particular, are LGBTQ participants more likely to have discussed homosexuality with families or in schools than heterosexual students?
- Are there significant differences between participants who were in relationships during the groups versus those who were single? Does this factor influence attitudes or behaviors?

Furthermore, this group could easily be modified for use in different settings or with different populations. Some possible suggestions include the following.

- School-based programs or after-school groups.
- Church-based community education groups.
- A couples-only group.
- A therapeutic group in which licensed therapists could guide participants in further exploration of personal experiences as they relate to group material.
- A parent-based group in which parents could explore ways to approach their own children's sexuality education.
- University residence hall programming, freshman orientation programming, health services, counseling and psychological services, LGBTQ resource offices, and/or general student groups.

Implications

Based on the findings and observations described above, recommendations have been outlined below for sexuality education programs in general and colleges and universities specifically.

For Sexuality Education Programs

Engage parents. Participants overwhelmingly indicated a preference for receiving sexuality education information from parents, and rarely indicated that this was where they had received the bulk of their sexuality knowledge. Programs such as the one evaluated here could easily be adapted for use with parents and families in school- or community-based settings. Such interventions may impact knowledge and attitudes among children and parents, contributing to higher levels of healthy sexuality for

individuals, families, and wider communities.

Attend to characteristics of the instructor. Participants rated leaders of the designed intervention significantly more positively than they rated their high-school sexuality education instructors. Developing positive rapport between students and instructors is likely to influence student attitudes through increasing openness and engagement. Instructors should be able to model comfort, inclusive and nonjudgmental attitudes, and openness to discussion of potentially taboo topics. Instructors should be willing to explore their own knowledge, attitudes and values regarding the material they present, and to model this exploration (e.g., demonstration of ways to seek information and evaluate its accuracy).

Allow and encourage student discussion. Group participants reported great appreciation for opportunities to discuss the material presented in each session, and often requested additional time for discussion (e.g., staying after group, using in-session posttest time for discussion instead, indicating a desire for additional sessions and more topics). Incorporating discussion into sexuality education programming is likely to facilitate the following two recommendations:

Address student attitudes and questions. Sexuality education experiences tend to vary widely, and many topics that may be characterized as “personal” (e.g., emotional/relational aspects of sex, student values and attitudes, sexuality and identity) tend to be overlooked in most sexuality education programs. These tend to be topics that young people are most interested in, and participants in the present study expressed appreciation for the integration of such topics in the group curriculum. School-based

sexuality education programs must consider the interests, motivations, and questions held by students to best address their needs.

Directly address stereotypes, myths, and misinformation. In the present study, participant ratings of satisfaction with sexual knowledge and rates of knowledge accuracy showed no correlation, implying that young adults are unaware of what they do and do not know with regard to healthy sexuality. This finding highlights the importance of sexuality education programs addressing pervasive stereotypes, myths, and misinformation about sex among youth—another content area that was absent in the sexuality education histories of many participants.

Do not fear diversity. Encouraging participation and discussion among students with varied identities, values, and lived experiences may enrich learning experiences for all members of the group or classroom. This can and should include co-ed learning environments, sexual and gender diversity (e.g., LGBTQ-identified students), racial/ethnic diversity, religious diversity, etc. Instructors should welcome diverse perspectives in their classrooms through modeling and maintaining an atmosphere of respect.

Provide resources. Rather than relying on school-owned health education materials, provide resources that students can refer to at any point in their future such as informational handouts, lists of trustworthy local and online resources, and recommendations for further reading.

For Colleges and Universities

Increase accessibility of sexuality education programming at the college level.

University students are likely to arrive on campus with significant gaps in their sexual knowledge and with limited awareness of these gaps. Students should be informed of programs to increase the accuracy of their sexual knowledge, and encouraged to participate. Programs such as the one examined here could easily be offered through a variety of campus offices, such as residence life, student health and wellness, and/or counseling services.

Provide clear information about local and campus resources. Many students on campus may not be aware of sexual health resources available to them in their communities and even within their university's student health center.

Recognize needs of LGBTQ-identified students. Recognize that LGBTQ youth are frequently rendered invisible in school-based sexuality education, and are likely to arrive on campus with significant gaps in their sexual knowledge. Resources for such students should be made available, including LGBTQ-targeted sexuality education programming as well as intentional inclusivity in general sexuality education programs.

Conclusion

Overall, the present study provides a glimpse into the state of healthy sexuality among young adults. Healthy sexuality is comprised of multiple constructs, including accurate knowledge, positive attitudes, risk-reducing behaviors, open communication among partners, and self-efficacy for creating desired experiences and preventing unwanted experiences (Edwards & Coleman, 2004). Assessment prior to the designed intervention exemplified the wide variety of educational experiences and sources that

young adults have, contributing to great variation in sexual knowledge, attitudes, behaviors, and self-efficacy. Assessment following the designed intervention demonstrated significant improvement in many of these areas, indicating that college students are likely to benefit from continued sexuality education (Synovitz et al., 2002). The level of interest for participation in the study supports hypotheses that young people hold desires for improving in each of these areas and study participants are owed a great deal of credit for success of the project. Participant engagement in discussion and self-reflection enriched the experiences of group members and leaders, and provided many ideas for further development and applications of the designed curriculum (von Sadovskzy et al., 2006). It is hoped that this and similar interventions will continue to contribute to ongoing conversations with young adults about increasing healthy sexuality and improving relationships, personal self-efficacy and sexual satisfaction.

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APPENDICES

Appendix A

Permission to Reprint Copyrighted Material

8/17/12

Dr. Eli Coleman
 Program in Human Sexuality
 University of Minnesota Medical School
 1300 South 2nd Street, Suite 180
 Minneapolis, Minnesota 55454

Dear Dr. Coleman,

I am in the process of preparing my Dissertation in the Department of Psychology at Utah State University. I hope to complete in the spring of 2013. My project involved the evaluation of a four-session psychoeducational group designed to increase aspects of healthy sexuality among young adults, particularly college students.

I am requesting your permission to include the table of definitions of sexual health from your 2004 article *Defining Sexual Health: A Descriptive Overview* published in the *Archives of Sexual Behavior*, Vol. 33 with Dr. Weston Edwards. I will include acknowledgements and/or appropriate citations to your work as shown in the attached document, and copyright and reprint rights information in a special appendix. The reference citation will appear at the end of the manuscript as shown below. Please advise me of any changes you require.

If this is acceptable, please indicate your approval by signing in the space provided and attaching any other form or instruction necessary to confirm permission. If you charge a reprint fee for use of your material, please indicate that as well. You may send a scanned copy of the signed letter via email, fax to 435-797-1448, or reply by mail to USU Department of Psychology, 2810 Old Main Hill, Logan, UT 84321. If you have any questions, please contact me by email at Brenna.M.Wernersbach@aggiemail.usu.edu or by phone at (763)234-2069, or my research supervisor, Dr. Renee Galliher at Renee.Galliher@usu.edu or (435)797-3391.

Thank you for your cooperation,

Brenna M. Wernersbach

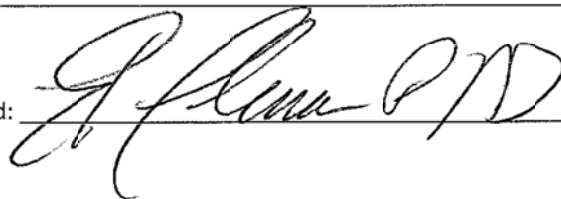
I hereby give permission to Brenna Wernersbach to reprint the following material in her dissertation.

Table I. Definitions of Sexual Health, p. 190

Edwards, W.M., & Coleman, E. (2004.) *Defining sexual health: A descriptive overview.*
Archives of Sexual Behavior, 33, 189-195.

Fee: _____

Signed: _____



Appendix B
Informed Consent



Department of Psychology
2810 Old Main Hill
Logan UT 84322-2810
Telephone: (435) 797-1460



Page 1 of 3
USU IRB Approved: Sept. 29, 2011
Approval Terminates: 09/28/2012
Protocol 3014
IRB Password Protected per IRB Administrator

INFORMED CONSENT

Healthy Sexuality: Evaluating a Psychoeducational Group Promoting Knowledge, Communication, and Positive Experiences

Introduction/ Purpose Brenna Wernersbach, a doctoral candidate, and Dr. Renee Galliher, an Associate Professor, both in the Department of Psychology at Utah State University (USU), are conducting a research study to find out more about college students sexual education histories, knowledge, behaviors, and attitudes, and to test the effectiveness of a co-ed group intervention in improving knowledge, self-exploration, and personal awareness in each of these areas. You have been asked to take part because you indicated that you are interested in learning more about healthy and positive aspects of sexuality. There will be approximately 60 total participants in this research, including people with various religious beliefs, relationship histories, current relationship statuses, and sexual orientations. If you agree to participate, you will be randomly assigned either to a group that begins immediately or to a wait list group that begins in approximately 3 weeks.

Procedures If you agree to participate in this research study, you will be asked to provide a certain amount of personal information by completing a number of forms asking about you and your life experiences. The forms you complete will include questions regarding your sexual education history, knowledge and attitudes about human sexuality, and experience with a variety of sexual behaviors. The information collected in this process will be kept confidential. After providing this information, you will be assigned to one of two groups, either a group that will meet twice a week for two weeks for 90 minutes at a time (the intervention group) or a wait-list group. The intervention group participants will participate in an intervention designed to increase knowledge about human sexuality, understanding of your personal values and boundaries regarding sex, and confidence in communicating about sex with others. The intervention will be somewhat like a class in nature; participants will learn scientifically factual information about human sexuality, explore their personal values and feelings about the information and the role of sex in their lives, and discuss with the group their reactions to the material presented.

Participants will be expected to attend each of the four sessions; if you are unable to commit to attending to each of the sessions, please see the alternative procedures section below for other options for receiving similar information, or speak with Brenna Wernersbach about alternative options. After the two-week intervention, all participants will once again complete the forms that will allow the researchers to assess the effectiveness of the intervention. It should be noted that the group intervention is experimental; it has been designed specifically for this project. Participants on the wait-list control group will have the opportunity to participate in the intervention group once forms have been completed, about two weeks after the initial group begins. Wait-list group participants will complete the same forms as the initial group participants. Six months following the completion of the group, you will be contacted by email to complete a final compilation of surveys online.

Alternative Procedures Instead of participating in this research, an alternative for you to consider would be seeking information from USU Student Health & Wellness, USU Counseling and Psychological Services, USU Sexual Assault and Anti-Violence Information, taking a course on human sexuality, or consulting books or the internet (e.g., scarleteen.com, sexctc.org, sexualhealth.com).



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INFORMED CONSENT

Healthy Sexuality: Evaluating a Psychoeducational Group Promoting Knowledge, Communication, and Positive Experiences

New Findings During the course of this research study, you will be informed of any significant new findings (either good or bad), changes in the procedures, risks or benefits resulting from participation in the research, or new alternatives to participation that might cause you to change your mind about continuing in the study. If necessary, your consent to continue participating in this study will be obtained again.

Risks Participation in this research study may involve some risks or discomforts. One risk pertains to confidentiality of participation in the group and information disclosed therein: although the group leaders are held to high standards of maintaining confidentiality, there are no such standards to hold other group participants accountable. The importance of respecting other group members and maintaining confidentiality will be emphasized to all members individually as well as in the group, but the researchers cannot guarantee that members will obey these group rules. Another risk is the possibility that you might become upset thinking and talking about some of the topics of this intervention. If this occurs, you have the option to exit from the intervention. If you have any questions or items you would like to discuss after your participation, or if you would like information about the results of the study, Brenna Wernersbach will be available for communication (see contact information below). Should you feel uncomfortable or want to speak to someone not associated with the study, it is recommended that you contact a therapist. Resources include USU Counseling and Psychological Services (435-797-1012), the USU Psychology Community Clinic (435-797-3401), and the USU Marriage and Family Therapy Clinic (435-797-7430).

Additionally, all studies involve at least the minimal risk of loss of confidentiality, but we will take steps to reduce this risk by storing all data collected in highly secure files and offices and de-identifying data at the earliest possible opportunity. Utah law does require researchers to report certain information to the authorities. This includes threat of harm to self or others, or abuse of a minor by an adult, and HIV positive status.

Benefits Personal benefits to participants are presumed to include increased knowledge, self-efficacy, and positive attitudes about the role of sex in their lives including a more clear understanding of how their personal values can be integrated with their sexual decision-making, and greater confidence in communicating about this with others. Further benefits of this study may result from knowledge shared by participants with their own friends and family, as well as potential for further development of this program for use with students at this and other Universities and other educational settings.

Explanation & offer to answer questions Brenna Wernersbach has explained this research study to you and answered your questions. If you have other questions or research-related problems, you may contact Ms. Wernersbach at (435) 797- 8254 or Brenna.M.Wernersbach@aggiemail.usu.edu. Alternatively, you can contact Dr. Renee Galliher at (435) 797-3391 or renee.galliher@usu.edu.

Voluntary nature of participation and right to withdraw without consequence Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. You may be withdrawn from this study without your consent by the



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2810 Old Main Hill
Logan UT 84322-2810
Telephone: (435) 797-1460



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INFORMED CONSENT

Healthy Sexuality: Evaluating a Psychoeducational Group Promoting Knowledge, Communication, and Positive Experiences

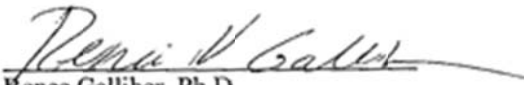
investigator if your behavior in the group is found to be disruptive or if the interventionists understand that participation in the group is somehow detrimental to you. If this occurs, Brenna Wernersbach will provide you with information about alternative services (see Alternative Procedures above).

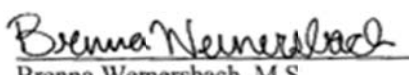
Confidentiality Research records will be kept confidential, consistent with federal and state regulations. Only Renee Galliher and Brenna Wernersbach will have access to the data, which will be kept in a locked file cabinet in a locked room. Personal, identifiable information will be kept for one year after the completion of the intervention and then destroyed. To safeguard against the loss of confidentiality from participating in the group intervention, all group members will explicitly agree to confidentiality at the outset of the group.

IRB Approval Statement The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu to obtain information or to offer input.

Copy of consent You have been given two copies of this Informed Consent. Please sign both copies and keep one copy for your files.

Investigator Statement "I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."


Renee Galliher, Ph.D.
Principal Investigator
(435) 797-3391
Renee.Galliher@usu.edu


Brenna Wernersbach, M.S.
Student Researcher
(435) 797-8254
Brenna.M.Wernersbach@aggiemail.usu.edu

Signature of Participant By signing below, I agree to participate.

Participant's signature

Date

Appendix C
Group Manual

Healthy Sexuality Group Manual & Handouts

Brenna M. Wernersbach, M.S.

Group Manual Overview

Session 1: Introductions, Anatomy and Sexual Response

- Leader and member introductions, process metaphor, group orientation
- Discussion of values, educational history and family/peer attitudes
- Anatomy module: slang terms, ice-breaker and anatomy worksheets
- Human sexual response handout and discussion
- Discuss material, address further questions, and introduce next topic
- *Handouts:* Process Metaphor, Female Anatomy Worksheet, Male Anatomy Worksheet, Masters & Johnson 4-Phase Model of Sexual Response Handout

Session 2: Communication

- Review previous week's discussion
- Discuss reasons for communication, pros and cons
- Effective Communication Discussion
- Role play and discuss material, address further questions, introduce next topic
- *Handouts:* Effective Communication, Yes, No, Maybe: Your Personalized List, Love in the Afternoon Role Play*, Conversation Starters/Setting Sexual Limits Worksheet*

Session 3: Safer Sex Practices

- Review previous week's discussion
- Discuss myths about safer sex (handout)
- STI prevention discussion (Sexually Transmitted Infections Handout)
- Pregnancy prevention discussion (Contraceptive Choices Handout)
- Basic safer sex kit handout and demonstration
- Supplemental worksheets and role plays
- Discuss material, address further questions, and introduce next topic
- *Handouts:* Safer Sex Myths, Contraceptive Choices, Sexually Transmitted Infections, Basic Safer Sex Kit, Common Condom Refusals Worksheet*, Condom Friendly Responses Worksheet*

Session 4: Preventing Unwanted Sexual Experiences, Group Termination

- What is an unwanted experience? Who is responsible? Discussion (Myths)
- Enthusiastic consent vs. no means no
- Prevention and support
- Discuss material, address final questions, end of group, and goodbyes
- Distribute resources guide
- *Handouts:* Sexual Assault and Rape Myths, Mr. Smith Activity*, Enthusiastic Consent vs. No Means No, Prevention and Support, Resources Guide

*Supplemental activity included in case of minimal group participation/discussion

Healthy Sexuality Group

Designed by: Brenna Wernersbach, M.S.

Rationale: Despite the so-called sexual revolution of the 1960's and 70's, sexuality (the expression of sexual behavior) remains a highly taboo subject among many Americans. Sexuality education for youth remains inconsistent and incomplete, and approaches to sexuality in psychology are typically focused on sexual assault and/or sexual dysfunction. The purpose of the Healthy Sexuality group is to present information to young adults on healthy sexuality, including a basic understanding of physical anatomy and sexual response patterns, communication with one's partner about and during sex, protection from pregnancy and sexually transmitted infections, prevention of unwanted sexual experiences and sexual assault, and integration of values and sexuality.

Group Leaders: Groups will be led by a female and male co-leader duo in order to model communication between genders. For the purposes of this study, groups will be led by graduate students in psychology who have been trained by the primary investigator. The group could also be led by health care professionals, mental health professionals, health educators, university residential hall advisors, etc.

Logistics:

- a. *Spaces to be used:* Group sized therapy room (USU Counseling and Psychological Services, USU Psychology Community Clinic), conference rooms (USU Student Health and Wellness Center, USU residence halls)
- b. *Number of students:* 6-10 co-ed participants per group
- c. *Age of students:* Variable, primarily college freshmen and sophomores living in on-campus housing (estimated ages 18-21)
- d. *Time of day:* Variable—will be determined based on participant and leader availability.
 - a. *Duration of the group:* Four 90-minute sessions across two weeks (two meetings per week for two weeks)

Goals:

- a. To educate young adults about sexual anatomy and sexual response in themselves as well as their (potential) partner(s).
- b. To develop efficacy in communicating one's values, desires, and boundaries regarding sexual contact with one's sexual partner(s).
- c. To gain an understanding of "safer sex" including prevention of unwanted pregnancies, prevention of sexually transmitted infections, and how to procure and utilize such preventative measures.
- d. To educate young adults about the prevention and prevalence of unwanted sexual experiences including (but not limited to) sexual coercion, "date rape," sexual assault, rape, and intimate partner violence. The responsibility of the perpetrator will be emphasized above self-protective strategies, although these

will also be discussed.

- e. To begin developing insight into the integration of one's value system with a healthy sexual life, including determining one's own values and their relation to cultural and familial values.

Overall approach: The degree to which the group operates as didactic versus discussion group is up to the group and the leaders. In general, groups should include the presentation and discussion of topical information followed by personal application of this information and discussing members' reactions to both hearing/learning *and* discussing this information.

Additional recommendations: It is appropriate to answer topical questions that fit the week's theme. If information relevant to the question will be discussed in upcoming sessions, it may be preferable to defer to that session rather than getting ahead of the group outline, but be sensitive to your participants' needs. If you are uncertain of the answer to a question posed by group members, be honest about your lack of knowledge and find the answer for them prior to the next session. This models comfort with admitting lack of knowledge and responsibility for accurate education.

It is recommended that group leaders procure a copy of *S.E.X.: The All-You-Need-To-Know Progressive Sexuality Guide to Get You Through High School and College* by Heather Corinna. This text covers the majority of the topics to be discussed in the group, and would be a useful reference to consult during the group should questions arise that group leaders are unsure of.

In groups that have an adequate foundational knowledge of the topics to be discussed, a relatively brief review of the didactic information may be appropriate, followed by a more extensive personal discussion of the topic. The review should not be overlooked however, as many people have less knowledge about sexual topics than they may admit to.

In groups that are reluctant to discuss personal applications of the topics, more time may be spent on structured activities and didactic information. However, don't shy away from discussing member reluctance to engage with the material. This is a rich example of confronting social taboos about sex.

It is important to model comfort discussing sexual topics when leading this group. Examine your own values and feelings about sexuality. Practice discussing sexual topics with your friends, and monitoring your emotional reactions. Admit your discomfort and examine where it comes from. It is also important to model genuineness and honesty.

Hello Healthy Sexuality group leader!

I'm so glad you will be involved in this project, and that you will be helping young people create healthy and positive sexual experiences! Your ability to model comfort with, or at least willingness to discuss, this material is going to make such a big difference.

In order to feel your most confident in the group and thereby increase your level of comfort in leading the group and fielding questions, please read the following sections of *S.E.X.: The All-You-Need-To-Know Progressive Sexuality Guide to Get You Through High School and College* by Heather Corinna for each module:

Session 1

- Introduction & Chapter 1 (p. 1-7)
- Chapter 2 (p. 12-15 & 31-42)
- Chapter 4 (p. 54-61, 63 “How do you tell” and “Buzz kills” sections)
- *Recommended: These readings are somewhat less directly tied to the module, but you may want to be familiar with them for fielding participant questions*
 - Remainder of Chapter 4 (masturbation and pornography)
 - Chapter 5—please read this chapter whenever you get the chance before leading the group

Session 2

- Chapter 7 (p. 139-144 “Be a blabbermouth”)
- Chapter 8 (p. 173-182)
- *Recommended:*
 - Chapter 8 (p. 149-173)

Session 3

- Chapter 9 (p. 201-222)
- Chapter 11 (p. 241-269)
- Appendix A
- *Recommended:*
 - Chapter 9 (p. 183-201)

Session 4

- Chapter 10 (p. 223-240)
- Chapter 13 (p. 296-298)

Please read Chapter 5 whenever you get the chance. There is no specific module that refers to this material, but you should do your best to incorporate examples that feature diverse types of relationships (p. 105-11) and are inclusive of LGBTQA individuals. Even if no one is out in your group, you should operate “as though” there could be. I highly recommend the entire book when you get a chance, and encourage you to bring it to each group session to look up answers to questions that you are unsure of. This is great modeling!

Session 1: Introductions, Anatomy, and Sexual Response

Part 1: Introductions (30 min)

- Goals:**
1. Group members acclimate to the group, get to know each other and the leaders, and share questions and concerns about participating in the group.
 2. Group members begin exploring and sharing their personal sexuality education history (including familial, peer, cultural, and religious influences).

I. Introductions (10 minutes)

- Group leaders introduce themselves, ask participants to share names
- Explain group “process”
 - **Participate**—be actively engaged in the group
 - **Respect**—respect the values and opinions of others even (especially) if you disagree
 - **Ouch/oops**—be willing to admit when a statement by a leader or other group member has hurt you, and be willing to admit when something you have said or done has hurt someone else
 - **Confidentiality**—respect one another’s privacy by not sharing personal information shared in group *outside* of group
 - **Empathy**—even when you feel you are coming from a significantly different place from other members of the group, make an effort to “step into their shoes” and understand their experiences and perspectives
 - **Step Up**—if you are the type of person who tends to observe rather than participate, challenge yourself to step up and engage
 - **Step Back**—if you are the type of person who tends to take leadership and share a great deal, challenge yourself to step back and allow room for other participants to share their experiences and thoughts
- Ask members if they have any questions about these group guidelines, and if they have any additional rules that they would like to establish as a group
- What questions or concerns do you have about participating in this group?
- What rules/structure would group members like to follow during the course of the group?
- What expectations to members have of their leaders? Of each other? (e.g., confidentiality, freedom from judgment, etc.?)

II. Member background and discussion of values (20 minutes)

- Personal goals—what do you hope to learn from this group or gain from this experience?
- Questions—do you have any questions up front that you hope to have covered over the course of the group?
- What are some common attitudes about sex and sexuality?
- What were your family’s values in this area, and what were they influenced by

(culture, religion, experience)?

- What were the values of your peer group growing up? Now?
- What are some of your values about sex and sexuality? How might they influence your experience in this group? Do you anticipate any challenges or conflicts between your values and participating in this group?
- How might you challenge yourself over the next two weeks?

Part 2: Anatomy and Sexual Response (60 minutes)

- Goals:**
1. To increase comfort in discussing sexual topics using sexual vocabulary.
 2. To solidify understanding of sexual anatomy and human sexual response.
 3. To dispel myths about male and female sexual anatomy and sexual response.

I. Ice breaker: slang terms (10 minutes: 5 for exercise, 5 for debrief)

- Using a dry-erase board, brainstorm a list of words that are used to refer to male and female anatomy. The goal of this exercise is to “break the ice” in the group, practice speaking and hearing sexual vocabulary, and spark discussion.
- If participants are reluctant to participate, have them write the terms on small slips of paper and collect these in a hat or bowl. Pass the bowl around and have participants read the terms out loud as a group leader records them on the board.
- “What are some slang terms about sexual anatomy that you have heard over the years?” (Male genitalia... Female genitalia...)
- What are members’ reactions to this activity (e.g., giggling, blushing, embarrassment, anger, offense)? Discuss reactions.
- Discuss why slang terms are so much more commonly used than “clinical” or “physiological” terms. (Discomfort, lack of knowledge)

II. Labeling activity (15 minutes—7 for work, 8 for discussion)

- Four worksheets will be distributed. Two diagram the typical female genital anatomy (internal and external), and the others diagram the typical male anatomy (internal and external). A list of terms is provided on each sheet, but group members must match the terms to their respective parts on the diagrams.
- Notify group members that they will each correct their own worksheet after they have been completed, and the worksheets **will not** be collected.
- When group members appear to have finished their worksheets, leaders should share the correct responses with the group by pointing out each structure on the diagram, pronouncing its name, and describing its function or reading its definition.
- Open the floor for questions. If none are shared, use prompts such as those below:
 - Did anyone feel really confused by the diagrams?
 - Were there names provided that people were unfamiliar with?
 - Normalize that many young people are unfamiliar with their own

genital anatomy and especially unfamiliar with the anatomy of an opposite sex partner.

III. Human sexual response (20 minutes)

- This may be a good place to discuss myths and misconceptions about human sexuality, or you may discuss this after the following handouts. Discussion points might include:
 - What are male and female motivations for sex? Stereotypes indicate that sex is about the physical experience for males and the emotional experience for women: do you agree or disagree with this notion? How does this apply to group members? How is this shaped by values?
 - What is the purpose or function of sex? Procreation? Enjoyment? Experience of intimacy? Orgasm?
- *Masters & Johnson 4-Phase Model of Sexual Response Handout*
 - Discuss similarities and differences between male and female sexual response
 - What are your cognitive and/or emotional reactions to this information?
 - How might our general views of sexual responsiveness be unfair to women or men?

IV. Discussion (13 minutes)

- What today like for group members? Many members likely experienced a great deal of discomfort, which they may or may not be willing to discuss.
- Examine why it is so uncomfortable to discuss sex when it is an arguably universal human experience. What are the benefits of discussing sex? What are the problems with discussing sex?

V. Plan (2 minutes)

- Next week's topic is communication about sex
- Hand out anonymous feedback form
 - What questions do you still have about today's discussion?
 - What questions do you have about next week's topic?
- This feedback will be used to make sure that group members questions are addressed, and allows students to give feedback and ask questions privately and anonymously.

Session 2: Communication

Goals: 1. To increase self-efficacy regarding communicating one's sexual desires and boundaries with partner(s) through increased knowledge, exposure, and practice.

I. Continue last week's discussion (5 minutes)

- Ask members to summarize what was discussed last week
- Revisit the discussion of discomfort in discussing sex

II. Reasons for Communication (10-15 minutes)

- Introduce the activity by explaining that while it is sometimes difficult to talk about sexual topics (including sexual limits, sexual behavior, and sexual history), it is an important topic.
- As a group, brainstorm the reasons why it's difficult to talk about these topics.
 - Examples may include: It's embarrassing. It makes you vulnerable. No one ever teaches or shows you how to do it.
- Next, brainstorm why it is important to communicate about sexual topics, including limit setting, sexual behavior, and sexual histories.
 - Examples may include: You should set limits. You can't read minds. So you don't go further than you want to. You avoid miscommunication.
- Discuss situations where it is easier to discuss sexual topics. Where is it more difficult? When is it easier to talk to a sexual partner about sex? What makes communicating about relationships and sexual issues difficult?

III. Effective communication (15-20 minutes)

- Discuss what sexual communication entails.
 - More than just asking what one person has or hasn't done before or wants to do.
 - Involves discussing each partner's boundaries, pace each partner is comfortable with, each partner's sexual health, what feels good and what doesn't, safer sex practices (e.g., contraception and STI prevention), sexual ethics and beliefs, and so on
- Discuss potential barriers to sexual communication.
- Distribute *Effective Communication* handout
 - Ask group members to read the handout aloud, point by point. Pause for discussion between relevant items. Particularly emphasize knowing your values and picking a safe location.
 - During discussion of either "Know your own values" or "Understand your own sexuality" points, distribute copies of the "Yes, No, Maybe: *Your Personalized List*" inventory.
 - Explain that this chart can be used to determine your own boundaries as well as to communicate them to your partner. You might start by thinking about an experience that you have

enjoyed or that you would like to have. Continue to write down everything you can think of sexually, even what you don't like. This can help you express to your partner what you are interested in, and what you're not into.

- This is a great point to show off your S.E.X. book: Chapter 8 (The Ins and Outs of Partnered Sex) could provide individuals with ideas of sexual activities to add to their list, plus it includes descriptions of the level of risk and other information about the variety of activities.
- Discuss how implementing these guidelines and tips may work in particular conversations. Examples may include:
 - Setting physical boundaries in a (new/ongoing) relationship
 - Determining safer sex practices (use of birth control, condoms)
 - Negotiating vastly different values regarding sex

IV. Conversation role-play (40 minutes: 10 min/role play, 20 min discussion)

- I. Each participant should pick out 2-4 *Conversation Starters* (already cut-up and in a small bag).
- II. Explain that the group will use the strips of paper in the bag to create a conversation between a hypothetical couple: Charlie and Sam. Charlie is excited to go further sexually, but Sam doesn't want to go as far as they went last time. To keep this organized, draw Charlie (a happy face saying "Yes!") and Sam (an uncertain face saying "hmm... No.") on the whiteboard.
- III. Divide participants into 2 equally sized mixed gender groups. One group will speak from the perspective of Charlie, and the other group will speak for Sam. To begin their conversation, either Charlie (group) or Sam (group) will read a line from one of the strips of paper. Groups may use the lines on the strips of paper in their bags to create a conversation about sexual limit setting, or they can generate their own responses. The conversation must end satisfactorily for both partners and the couple can't break up. It will be considered "resolved" when the Charlie group accepts Sam's position.
- IV. After this conversation has finished, have the groups exchange roles (Sam group now speaks for Charlie and vice versa) but retain their original statement slips. Try the conversation again with these reversed roles.
- V. Discussion: What was it like to speak from each perspective? What would be different about having this conversation with your own partner? Will it be easier to have this kind of conversation now that you have suggested words? Why or why not? What learning can you take from this experience to inform your next conversation about sexual boundaries?

V. Supplemental Activities (as needed to fill 40 minutes set for role-plays)

- Ask participants to write down “scripts” or statements demonstrating how they would use communication skills with a partner in the situations described above.
 - Ask participants to pair up with a neighbor and share their written responses with one another. If anyone is willing to read theirs aloud to the group or practice them through a role-play, encourage this.
- Utilize the *Love in the Afternoon worksheet*.
 - Have participants write responses to each of the statements on the worksheet, then share with a neighbor. If anyone is willing to read theirs aloud to the group or practice them through a role-play, encourage this.
- In pairs or small groups, brainstorm a list of “opening lines” for conversations about sex within a romantic relationship (e.g., “I think we need to talk about how far we’re going to go.”).
 - After groups have had time to generate their list, bring participants together and ask each group to share their list.

VI. Discussion (13 minutes)

- Try to monitor your group’s need to further explore the information presented during this session, and allow adequate time for discussion of personal and emotional reactions to the material discussed today

VII. Plan (2 minutes)

- Next week’s topic is safer sex practices
- Hand out anonymous feedback form

Session 3: Safer Sex Practices

Goals:

1. To increase factual knowledge about sexually transmitted infections (STIs) and pregnancy prevention.
2. To debunk group members' misconceptions and falsely held myths about what constitutes safer sex practices.
3. To help members develop plans for crafting their own safer sex kit, including an understanding of how to correctly utilize condoms and dental dams.
4. To provide members with information about how and where they can obtain devices for safer sex, including condoms, birth control, and STI testing and treatment in their local community.

I. Review last week's discussion (5 minutes)

- What did you learn about communication?
- What are some situations where these skills will be necessary?
- Hopefully someone will mention safer sex practices, segueing into...

II. Myths about safer sex (30 minutes for points II—IV distributed as needed)

- Why discuss safer sex practices? (or, how to combat “this doesn't apply to me”)
- *Members who value waiting until marriage for sex* may feel that this information isn't relevant to them—discuss ways that it is. For instance, one or more partners may have had varying levels of sexual contact with others prior to marriage despite their values [abstinence is difficult for many people]. Additionally, many married couples choose to delay pregnancy.
- *Male members* may feel that birth control information is just for women—discuss reasons that males who have or plan to have female partners should be informed about birth control options, expenses, side-effects, etc.
- *LGBTQ members* may feel that birth control information is just for straight participants—discuss reasons they may still benefit from this information, such as supporting friends and family in heterosexual relationships. Additionally, it is a common misconception that lesbians are not at risk for STIs, so discussing the use of dental dams, gloves, and other barrier methods for STI prevention, as well as STI testing and treatment, in female partnerships is important.
- Open discussion (monitor reactions)
 - What does “safer sex” even mean?
 - What are some things that you have heard about “safer sex”?
 - What methods have you heard of?
 - What reasons exist for us to be concerned about “safer sex”?
 - If participants are reluctant to participate, have them write some

methods or myths on small slips of paper and collect these in a hat or bowl. Pass the bowl around and have participants read the slips out loud. Discuss each point as needed.

- See handout on common myths to facilitate discussion and correct common misconceptions
- Points to emphasize include:
 - Safer sex practices don't make sex 100% safe, even if all of them are used perfectly. They are a lot like seat belts: even with one, we may still get hurt, but it's a whole lot less likely than if we ditch them altogether.
 - If you are sexually active (and even if you aren't, but people you know are), it is important to accept that STI transmission is always possible, and doesn't mean that a person is dirty, damaged, or deserved it.
 - Most STIs *are* both treatable and curable as long as they are diagnosed early. It is important for all young adults—women *and* men, and not just those who are sexually active—to have regular (annual) sexual health exams. (For more information on what these entail, see S.E.X. chapter 9)

III. Sexually Transmitted Infection (STI) prevention

- Most forms of contraception DO NOT protect against STIs (see *Contraceptive Choices* handout for further information)
- Whose responsibility is STI protection? The woman's? The man's? What about same-sex relationships?
- What are the most commonly used methods for prevention of transmission of sexual infections?
- What are STIs? How are they transmitted? Are they curable? (See *STI handout*).
- What does it mean if someone *has* an STI? (Be prepared to discuss and debunk stereotypes about promiscuity and value judgments of individuals who contract STIs.)
- Notify members that they should feel comfortable and prepared to discuss STI diagnosis and treatment with their health care provider. They can find free information at plannedparenthood.org or by communicating with their local Planned Parenthood clinic. Planned Parenthood also offers discounted rates on many forms of STI protective measures, STI testing, and STI treatments.
- Notify members that they can pick up free condoms at the Student Health and Wellness center or Planned Parenthood.

IV. Pregnancy planning and prevention

- Pregnancy prevention is probably the primary concern of many sexually active individuals.
- Whose responsibility is pregnancy prevention? The woman's? The man's?
- What are the most commonly used methods for prevention of pregnancy? How

much do you know about these methods? Where can the methods be obtained? How much do they cost?

- Use the *Contraceptive Choices* handout to discuss different options that members mention and debunk misconceptions they may have.
- Points to emphasize include:
 - Abstinence: About 26% of young adults “practicing abstinence” will become pregnant within one year—that makes it about 74% effective, less effective than most other methods. It’s best to be realistic about abstinence: if you’re with an opposite sex partner and are physically intimate at all, it’s best to have a backup method of birth control around and available just in case. You’re no less abstinent if you have one on hand but still refrain from sex.
 - Condoms: Effectiveness with perfect use is 98%, with typical use is 85%. Condoms most commonly fail when they are not used for all genital contact from start to finish, and can also fail by breaking, tearing, or slipping off. Proper condom use will be discussed later in the session. If a condom fails, it is almost always fairly obvious and emergency contraception can be considered. Other benefits of condoms include increasing a male’s endurance and easy clean up afterwards, plus they are the *only* contraceptive that also protects against STIs.
 - Hormonal methods: (e.g. the pill, the ring, the shot, the implant) work by putting hormones into the bloodstream that alter the normal fertility cycle, making conception very unlikely. They may do any or all of the following: keep eggs from being released each month, thicken cervical mucus to make it difficult for sperm to reach and fertilize the egg, and/or prevent a thickening of uterine lining so that a fertilized egg cannot implant.
 - Emergency contraception: (aka The Morning After Pill) can decrease the risk of pregnancy by 75-89% when used within 120 hours (5 days) of unprotected sex. It costs between \$25-50, has very few side effects, and is easy to use. *The morning after pill is not an abortion pill—it can prevent pregnancy but not terminate an existing pregnancy.* It works by introducing the same hormones into the body that are contained in hormonal birth control methods, but in a higher dose, and works the same way: by inhibiting or delaying ovulation, preventing fertilization of the egg, and/or inhibiting implantation of a fertilized egg.
 - Withdrawal: (aka “pulling out”) the male partner withdraws (pulls out of the vagina) before ejaculating. *This is a risky method that is not considered reliable.* Many men (especially young men) may have a hard time anticipating when exactly ejaculation is beginning, withdraw after ejaculation has begun, or get caught up in the moment and forget altogether. This puts all of the responsibility on the male partner, and gives the female partner little to no control.
- Notify members that they should feel comfortable and prepared to discuss

contraceptive options with their partner(s). Points to discuss include effectiveness, ease of use, and availability; backup plans; responsibility; and what to do if the method used fails.

- Notify members that they should feel comfortable and prepared to discuss contraceptive options with their health care provider. They can find free information at plannedparenthood.org or by communicating with their local Planned Parenthood clinic. Planned Parenthood also offers discounted rates on many forms of contraceptives, as well as pregnancy testing.

V. Safer Sex kit demonstration (15 minutes)

- Group leaders will prepare and present a basic safer sex kit with the following items:
 - Unlubricated or lubricated condoms
 - Latex-safe lubricant
 - Latex gloves (or nonlatex for those with allergies)
 - Dental dams (or a small scissors for cutting condoms or gloves to use as dams)
 - Baby wipes (for quick cleanup of genitals, especially after using flavored lubes or condoms or silicone lubricants)
 - A over-the-counter analgesic, such as aspirin, acetaminophen, or ibuprofen (helpful for soreness due to vasocongestion (aka “blue balls”))
 - Aloe vera gel (handy for external genital irritation after sexual activities)
- Distribute handout with list of items and safer sex kit rationale and suggestions, as well as condoms to get their kits started with. Make sure everyone takes some—even if they protest and say they won’t use them tell them they can stash them in a drawer, give them to sexually active friends, or throw them away later.
- Discuss whether there are other items that members might recommend including in a safer sex kit.
- Discuss what it would be like to shop for these items, discuss the kit with a partner, or simply pull a kit out when you are ready to be sexually active.
- If a person feels that she or he could not afford these basic supplies, they can’t afford to be sexually active. Safer sex gear will be the least of a person’s expenses, and is worth the investment (e.g., emergency contraception, STI testing and treatment, accidental pregnancy, etc.)

III. Condom Refusals Dialogue (25 minutes)

- Each participant should pick out 1 *Condom Refusal* and 1-2 *Condom Friendly Responses* (already cut-up and in a small bag).
- Explain that the group will use the strips of paper in the bag to continue their conversation between hypothetical couple Charlie and Sam. Sam is now ready to engage in sexual activity with Charlie, but does not want to use a condom. Charlie, on the other hand, insists that they use protection for engagement in oral or penetrative intercourse.

- Divide participants into 2 equally sized mixed gender groups. One group will speak from the perspective of Charlie, and the other group will speak for Sam. To begin their conversation, Sam (group) will read a refusal from one of the strips of paper. Groups may use the lines on the strips of paper in their bags to create a conversation about incorporating safer sex practices. Because there are less scripts for this activity, members will need to generate their own responses more frequently than last week. The conversation must end satisfactorily for both partners and the couple can't break up. It will be considered "resolved" when the Sam group accepts Charlie's position.
- After this conversation has finished, have the groups exchange roles (Sam group now speaks for Charlie and vice versa) but retain their original statement slips. Try the conversation again with these reversed roles.
- Discussion: What was it like to speak from each perspective? What would be different about having this conversation with your own partner? Will it be easier to have this kind of conversation now that you have suggested words? Why or why not? What learning can you take from this experience to inform your next conversation about safer sex practices?

IV. Discussion (13 minutes)

- How does the information today relate to your values regarding sex?
 - See discussion points from today's introduction for prompts (ex. those waiting for marriage, male members, LGBTQ members)
- How might you use last week's tips about communication to discuss this information with a sexual partner?
- What came up for members in group today (ex. confusion, discomfort, value judgments)? Discuss as needed.

V. Plan (2 minutes)

- Next week's topic is preventing unwanted sexual experiences
- Hand out anonymous feedback form

Session 4: Promoting Positive Sexual Experiences, Group Termination

Part 1: Preventing Unwanted Sexual Experiences (30 minutes)

- Goals:**
1. To normalize and validate the experiences of group members who have experienced unwanted sexual encounters.
 2. To challenge myths and stereotypes about sexual assault, rape, and victim responsibility.
 3. To introduce the enthusiastic consent model, emphasizing the importance of mutual consent and enthusiasm in partnered sex.
 4. To suggest ways to protect oneself, support survivors of unwanted experiences, and challenge “rape culture” (e.g., sexism, objectification, victim-blaming, rape jokes, etc.).

I. Review last week’s discussion (5 minutes)

- a. What did you learn about safer sex practices?
 - Notify the group that there is quite a bit of information to pack into today’s session, including promoting positive sexual experiences/preventing unwanted sexual experiences, reflecting on what has been accomplished over the group as a whole, saying good-byes, and completing follow-up measures. This means that the didactic information presented today will come rapidly, and that there won’t be a lot of time for personalized discussion of or reactions to the material. As needed, remind participants of other resources on campus where this material can be further processed, such as USU Counseling and Psychological Services or the Sexual Assault and Anti-Violence Information (SAAVI) office.

II. What is an unwanted sexual experience? (15 minutes for points II—III)

- Guide this discussion so that experiences outside of stereotypes or media representations are mentioned.
- Refute common myths listed on the sexual assault and rape myths handout. Prompt members to share other myths.
- Points that should be mentioned include the following:
 - Sexual assault: groping, forced kissing, being forcibly touched by another person or forced to touch another person, flashing, forced oral sex, forced anal sex, forced vaginal sex; sexual assault occurs by force, threat, surprise, intimidation, or by taking advantage of someone's helplessness or inability to consent.
 - Rape: occurs when a person is forced into a sexual act against their will, with physical force or some form of strong coercion. If a person consents under threat, or if the person has been given drugs or alcohol to produce consent, that is also rape. Often has subcategories:___
 - “Forcible rape” generally implies physical force or full-body violence. This is one of the most common media

representations, even though it is not the most common form of rape (this is discussed on the Rape Myths handout). This is a problematic stereotype, as rape is by definition forcible, and requiring violence as a component of the definition contributes to a culture of survivor-shaming/blaming.

- “Date rape” or “Acquaintance rape” applies to a rape committed by someone known to the survivor. Similarly, “spousal rape” refers to a rape that has occurred between married people.
- Coercion: pushing or pressure from a friend or partner to cross one’s sexual boundaries in order to please someone else.
- Other unwanted sexual experiences:, being “taken advantage of” during a “weakened” state such as emotional vulnerability, intoxication, or overtiredness, any form of sexual activity that occurs without any participant’s enthusiastic consent
- Unwanted sexual experiences can occur within a loving partnered romantic relationship, within a friendship, within a family, by an acquaintance, or by a complete stranger.
 - Do not force members to refer to all experiences of unwanted sexual experiences as sexual assault—it is important to allow them to use their own labels. Even if members have experienced sexual assault or rape, they might not be willing to recognize this in such strong terms at this point.

III. Who is responsible for unwanted sexual experiences?

- A great deal of media, news agencies, and public opinion today tend to put fault for sexual assault on the person without power in the situation—this is often referred to as “blaming the victim.”
- Most of these “tips” target women who must “protect themselves” from male assailants. While there are things that women can do to protect themselves, the responsibility for sexual assaults should rest with the perpetrators of sexual assault, just as any other perpetrator of any crime is held responsible rather than the victim (e.g., mugging, drunk driving, etc.).
 - If discussion is lacking, use one of the following prompts:
 - Here is an example from an internet advice column:
 - “Here are a few things that you can do to help prevent it from happening to you. There are the obvious things that we all must do. Avoid going out at night. If you must don't go alone or at least go where it is well lighted. Park close to the store or place that you need to go too. Have your keys in your hand with the keys pointed out so that if you need to protect yourself you have them in your hands. Have your cell phone available and easily assessible [sic]. Also have mace or hairspray, something that you can use if you need to. The less obvious things that are important is to walk with purpose and confidence. Keep your

head up and back straight. Attackers will purposely seek out those who look vulnerable, meek and afraid. It is not your fault, but they are going to go for the ones that they see that are the most likely victims. Unfortunately those who have been victimized before are the most likely to be targeted. Even though you may not feel it, act as if! Rapists and attackers, are cowards, and they are going to go after those that appear the most vulnerable.”

- **Q. What is the problem with this?** A. This puts responsibility for safety on women and forces them to live in fear of their world.
- See the Mr. Smith activity in the handouts section. Have two group members read the dialogue, then discuss reactions.

IV. Enthusiastic consent (5 minutes)

- Beyond “no means no” emphasize “YES! means yes.”
 - See enthusiastic consent handout for an explanation of the enthusiastic consent model
- What does “yes means yes” mean? What does “no means no” mean? What is left out of these two “catch phrases”?
- **Emphasize communication.** Sexual violence often goes hand in hand with poor communication. Our discomfort with talking honestly and openly about sex dramatically raises the risk of rape. By learning effective sexual communication -- stating your desires clearly, listening to your partner, and asking when the situation is unclear -- men make sex safer for themselves and others.
- How can you tell when you are being pushed beyond your boundaries? What are the physical sensations you experience, the thoughts that go through your head, your “gut instinct”? Inversely, how can you tell when you are being respected?
- How would you communicate to a partner that you are no longer comfortable in a sexual situation or with the status of your sexual relationship? How would you ask them about their comfort level?
 - If participants are reluctant to discuss the applications of the material presented, ask them to write down “scripts” or statements demonstrating how they would use these skills with a partner. Ask participants to pair up with a neighbor and share their written responses with one another. If anyone is willing to read theirs aloud to the group or practice them through a role play, encourage this.

V. Prevention (10 minutes for points V—VI)

- Things women AND men can do to protect themselves and others:
 - See prevention handout
 - Discuss the atmosphere that rape jokes create. (Uneasiness, lack of

accountability, disbelief of reports, etc. Additionally, 1 in 4 women will experience sexual assault during her lifetime, so chances are you are personally mocking someone you know. Would you allow this to go on if you *knew* a rape survivor was in your midst?)

- Would you laugh at this type of joke? Would you refrain from laughing? Would you call someone out about this type of humor?

VI. Discussion

- Discuss today's topic as needed. Because it is highly personal, be prepared to offer individual support to members as needed. It may be appropriate to offer referrals to SAAVI or CAPS for individual consultation rather than process personal experiences in group.

Part 2: Termination (60 minutes)

Goal: 1. To bring a sense of closure to the end of the group.

I. Discuss any final questions that members feel are still unanswered

II. Discuss the end of the group (40 minutes)

- What has your experience been as a member of this group?
- What have you learned?
- What was the most important message that you will take away from the group?
- What pieces of the group were most upsetting to you?
- What will you do with the information you have learned?
- What will you do when future questions arise?
- How has the group changed the way you are outside of group?

III. Goodbyes (20 minutes)

- Allow room for members to give one another feedback, and to give leaders feedback, about what they have observed in one another
- Allow members to share what the end of the group means to them
- Distribute the References handout and encourage group members to continue seeking out further answers to their questions on their own and with friends and partners

Appendix D
Group Handouts

Next session's topic is _____

What would you say were the best or most effective pieces of today's group?
(For example, what activities did you like best and why? What information was the most useful to you? What new things did you learn?)

What would you say were the least helpful or effective pieces of today's group?
(For example, what activities did you dislike and why? What information seemed irrelevant or unimportant? What seemed to be missing?)

What questions do you still have about today's discussion?

What questions do you have about next session's topic?

- P Participate**—be actively engaged in the group
- R Respect**—respect the values and opinions of others even (especially) if you disagree
- O Ouch/oops**—be willing to admit when a statement by a leader or other group member has hurt you, and be willing to admit when something you have said or done has hurt someone else
- C Confidentiality**—respect one another’s privacy by not sharing personal information shared in group outside of group
- E Empathy**—even when you feel you are coming from a significantly different place from other members of the group, make an effort to “step into their shoes” and understand their experiences and perspectives
- S Step Up**—if you are the type of person who tends to observe rather than participate, challenge yourself to step up and engage
- S Step Back**—if you are the type of person who tends to take leadership and share a great deal, challenge yourself to step back and allow room for other participants to share their experiences and thoughts

Female Anatomy Terms

Match the letters of the definitions on the right to the terms on the left.

Key: 1. E 2. F 3. B 4. C 5. D 6. A 7. L 8. K 9. N 10. M 11. I 12. J 13. G 14. H
--

- | | |
|--|---|
| ____ 1. Vaginal Opening

____ 2. Vagina

____ 3. Clitoris

____ 4. Mons Pubis

____ 5. Labia Minora

____ 6. Labia Majora

____ 7. Ovaries

____ 8. Fallopian tubes

____ 9. Cervix

____ 10. Uterus

____ 11. Bladder

____ 12. Urethra

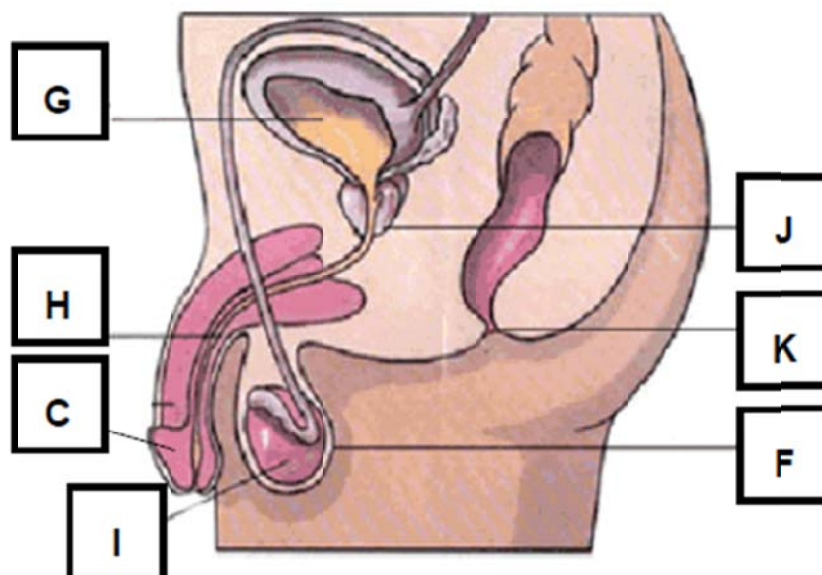
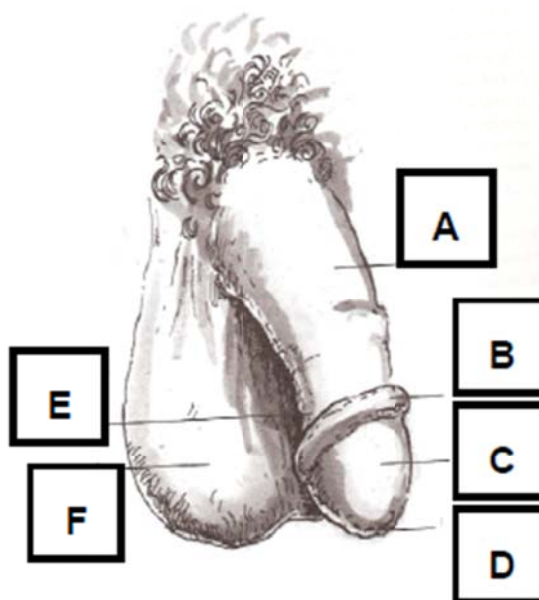
____ 13. Urethral Opening

____ 14. Anus | A. Some people call them the large or outside lips. Primary function is to protect the rest of the vulva.
B. The structure protruding or sticking out from where the labia minora join; the most sexually sensitive female sex organ. Exclusive function is sexual pleasure.
C. The entire triangle shaped area above the vulva that contains hair.
D. Some people call them the small, inside lips. They can sometimes hang lower or be larger than the labia majora. Primary function is to protect other structures.
E. This opening leads to the vagina.
F. A muscular tube that is important as a female organ of reproduction and sexual pleasure.
G. This is where urine from the bladder comes out and is the opening to the urethra. (NOTE: Women do not urinate from the vagina)
H. The opening through which the solid refuse of digestion is excreted.
I. A sac in which urine is retained until it is discharged from the body.
J. The tube that passes from the urinary bladder to the outside of the body.
K. Structures that are connected to the uterus and lead the ovum from an ovary to the inner cavity of the uterus.
L. Pair of female gonads, located in the abdominal cavity, that mature ova and produce female hormones.
M. A thick-walled muscular organ that provides a nourishing environment for a developing fetus during pregnancy.
N. Latin for neck, this is the passage from the uterus to the vagina. |
|--|---|

Male Anatomy Worksheet

Match the letters from the diagrams to the terms listed below. Then move on to the definition matching items on the back of this page.

- ___ 1. Glans
- ___ 2. Corona
- ___ 3. Shaft
- ___ 4. Frenum/Frenulum
- ___ 5. Scrotum
- ___ 6. Testes
- ___ 7. Urethral Meatus
- ___ 8. Bladder
- ___ 9. Prostate
- ___ 10. Urethra
- ___ 11. Anus



Key:

- 1. C
- 2. B
- 3. A
- 4. E
- 5. F
- 6. I
- 7. D
- 8. G
- 9. J
- 10. H
- 11. K

Male Anatomy Terms

Match the letters of the definitions on the right to the terms on the left.

- | | |
|--------------------------|---|
| _____ 1. Glans | A. Pair of male gonads that produce sperm and male hormones |
| _____ 2. Corona | B. Sensitive, smooth and rounded head; filled with nerve endings and particularly sensitive to sexual stimulation |
| _____ 3. Shaft | C. The opening of the urethra |
| _____ 4. Frenum/Frenulum | D. Thin, tightly drawn fold of skin on the underside of the penile glans; highly sensitive. |
| _____ 5. Scrotum | E. Cylindrical base of penis that contains three columns of spongy tissue. |
| _____ 6. Testes | F. The ridge along the edge at the bottom of the glans. |
| _____ 7. Urethral Meatus | G. The membranous tube that extends from the bladder to the exterior that in males conveys semen as well as urine |
| _____ 8. Bladder | H. A sac in which the urine is retained until it is discharged from the body |
| _____ 9. Prostate | I. The opening through which the solid refuse of digestion is excreted. |
| _____ 10. Urethra | J. Pouch of skin in which the testes are contained |
| _____ 11. Anus | K. Gland producing some of the secretions in semen enhancing the mobility and fertility of sperm. |

Key:

- | | |
|-----|---|
| 1. | B |
| 2. | F |
| 3. | E |
| 4. | D |
| 5. | J |
| 6. | A |
| 7. | C |
| 8. | H |
| 9. | K |
| 10. | G |
| 11. | I |

Masters & Johnson 4-Phase Model of Sexual Response

Phase 1: Excitement

- May be initiated by physical, intellectual, emotional, or hormonal stimuli.
- The body begins to show signs of arousal. Blood pressure rises, breathing quickens, heart gets all “fluttery,” and skin may become flushed.
- Body becomes more sensitive and receptive to touch.
- Blood is routed to the pelvic region resulting in earliest signs of arousal.
- Female response: erection of the clitoris, vaginal lubrication.
- Male response: erection of the penis

Phase 2: Plateau

- Intensity of the body’s reaction to sexual arousal gradually builds to this level, where it is maintained for varying lengths of time.
- May be a major highlight of sexual response.
- Intensity may ebb and flow (B) and provide special “highs” of sexual enjoyment
- Female and male responses are similar and include: further increases in muscular tension, respiration, heart rate, and blood pressure.

Phase 3: Orgasm or Climax

- Buildup of tension during plateau phase may trigger a pleasurable sexual release. Orgasm not only feels different from person to person, it often feels different for any *one* person from day to day, experience to experience.
- Brief phase, lasting a few seconds to approximately 1 minute.
- Female response: uterus undergoes wavelike contractions, some women may ejaculate a liquid substance from the urethra (but whether this is tied to orgasm or simply advanced arousal is uncertain)
- Male response: contractions of the pelvis, prostate gland, vas deferens, and seminal vesicles, which usually (but not always) cause the ejaculation of semen
- Female and male responses: spasms of some muscles; peak intensity of respiration, heart rate, and blood pressure.

Barriers to arousal & orgasm may include...

- General stress
- Tiredness or poor health
- Going without safer sex or reliable birth control (worry)
- Rushing
- Worries about being discovered or “caught”
- Feeling pressured by a partner, yourself, peers, or the situation to be aroused or achieve orgasm
- Past or current sexual abuse or trauma
- Some medications
- And the biggest one of all...
Psyching yourself out by trying way too hard to be aroused or achieve orgasm.

Phase 4: Resolution

- The body relaxes and begins to return to its unexcited state.
- Female response: some women may experience multiple orgasms before reaching this point through restimulation.
- Male response: refractory period—a period of time during which one cannot be restimulated to ejaculation (duration may vary based on amount of available sexual stimulations, mood, and age)

Sources: Corinna, H. (2007.) S.E.X.: The All-You-Need-To-Know Progressive Sexuality Guide to Get You Through High School and College.; Kelly, G.F. (2006.) Sexuality Today: The Human Perspective, Eighth Ed.

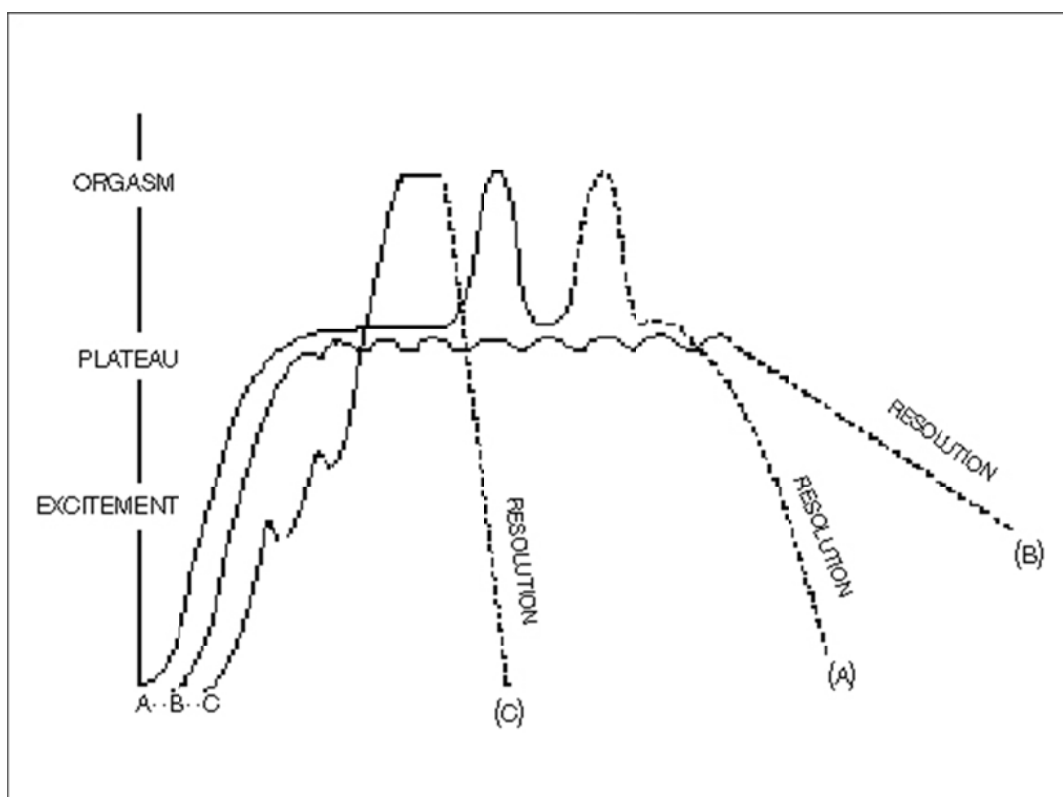


Image from Masters WH, Johnson VE. Human Sexual Response. 1966.

Arousal Scale

0 = Neutral, 10 = Orgasm



Arousal Level	Type of Touch	Description	Examples
8-10	Intercourse Touch	Penetrative intercourse	Vaginal intercourse Anal intercourse
6-10	Erotic Touch	Non-intercourse genital pleasuring	Oral stimulation Manual stimulation Kissing, rubbing
4-6	Playful Touch	Non-intercourse genital pleasuring	Dancing together Full body massage Bathing together
3-4	Sensual Touch	Non-genital Clothed, semi, nude	Warm, close touching Feel well connected Cuddling
0-3	Affectionate Touch	Non-genital Clothed	Hugging, kissing Hand holding

Adapted from Barry W. McCarthy, Ph.D. February 10, 2011 Restoring & Revitalizing Marital Sexuality presented in SLC, UT.

Effective Communication: Ground Rules

For the most part, people do not find it easy to communicate about the more intimate aspects of their lives, such as their sexuality. There are some preliminary steps to opening up channels for effective communication between two people about sex or any other sensitive topic. Here are some ground rules to get started:

1. *Think about the degree of commitment you hold for each other and the relationship.* Not much will happen with two-way communication unless *both* partners really want it to happen. Communicating honestly about sex takes energy. You may begin to feel tired, frustrated, or hopeless at times, and it will take a solid commitment from both people to see you through the more difficult steps. Relationships in which sex is discussed may exist on many different levels from the casual encounter in which two people barely know one another to the long-term loving involvement where discussing sex is continually necessary to ensure mutual satisfaction.
2. *Know your own values.* Before you try communicating about sex, it is a good idea to have thought through where you stand on the value issues that may be involved. Know your own beliefs, while letting yourself be open to the attitudes and values of the other individual.
3. *Understand your cultural differences.* If you are building a relationship with someone who has a cultural heritage different from your own, it will be important to first develop some fundamental understanding about how you may differ in the words or expressions you may use or in your levels of comfort in dealing with sexual issues. It is a good idea to spend some time discussing potential areas of conflict or misunderstanding before they turn into problems.
4. *Keep yourselves on equal ground.* A sense of equality between two people is usually essential to their communicating well. If someone is always feeling inferior in sensitive conversations, it is not likely that they will be able to communicate very openly or confidently. Power inequalities are dangerous to relationships.
5. *Build trust for one another.* When there is a lack of trust between two partners, there is likely to be not only a strain in their sexual interactions, but also a tendency toward reserved and uncomfortable communication. A sense of trust is fundamental to honest, genuine dialogue. Lack of trust can lead to “stonewalling” the other person during communication, a practice that can create serious obstacles in relationships.
6. *Pick the right location and time for talking.* Where and when you talk may be very important. You will both want to feel as relaxed and comfortable as possible and have adequate privacy. Sometimes bed is the ideal place to talk, but it may also produce an emotionally charged situation for some kinds of communication. Beware of atmospheres that encourage superficial conversations (ex. overly public spaces). Ask your partner where she or he would feel most comfortable talking, and be certain that you feel comfortable and safe there as well.

Source: Kelly, G.F. (2006.) *Sexuality Today: The Human Perspective*, Eighth Edition

Other tips:

Demonstrate an attitude of warmth, caring, and respect. It is not enough to feel a sense of caring for another person; the feelings need to be demonstrated in some way. Sometimes it may be a simple willingness to be quiet and listen attentively; other times it will require overt expressions of love or kindness.

Avoid making snap-judgments. Most people open up best to those who are not judgmental. Intimate communication will be improved if we can set assumptions aside and allow other points of view to be expressed openly.

Listen carefully and really hear. Let yourself hear the other person out, then think through your reactions and responses rather than thinking ahead or formulating your response before your partner has finished talking.

Empathize and understand that feelings need to be felt. Empathy can help ward off our natural tendencies to become defensive when we are facing disagreements. When listening to your partner, listen for feelings as well as content.

Be genuine. Work at being honest and being yourself in personal communications. Some level of self-disclosure about one's sexual feelings and needs seems to enhance sexual satisfaction within relationships.

Make sense and ask for clarification. It's a good idea to occasionally check your understanding by making statements like "What I hear you saying is..." or "Do you mean...?" This clarifies your interpretation and allows your partner to correct any misconceptions.

Don't let silence scare you. Take your time, allowing silence to be a part of communication at times. It can be intimate and calming as well.

Beware of the "I don't want to hurt you" trap. In relationships, hurtful things must be shared. This type of confrontation is not always easy, but in the long run it will help get tension-producing conflicts resolved.

Understand your own sexuality. Our society does not encourage much sense of our "ownership" over our own bodies until we reach some arbitrary age of passage when we are suddenly expected to become sexually responsible. This results in a good deal of confusion about sexual values and behaviors, and often leads us to engage in sexual activities out of a sense of obligation rather than a conviction that they are right for us. We need to be open to our sexuality so that we can think and plan ahead. We never have to be at the mercy of whims or urges, whether our own or those of others. It takes introspection, time, and even some experimentation to know where we stand with sexual values and what we want for our lives sexually.

Source: Kelly, G.F. (2006.) *Sexuality Today: The Human Perspective*, Eighth Edition

- 5 - Most Likely, Yes
- 4 - Likely
- 3 - Maybe
- 2 - Probably Not
- 1 - No

Yes, No, Maybe: Your Personalized List

What activities are you already comfortable with?
 Uncomfortable with?
 Interested in trying?

Activity	Willingness (1-5)	Experience (Yes or No)	Notes, Nuances, Thoughts

LOVE IN THE AFTERNOON ROLE PLAY

You and your partner are hanging out after school, watching TV. You decide to lie down on the couch together and you start to get close. This is exactly what happened the last time you went further than you wanted to sexually. You have decided that you don't want to go as far with your partner as you did before.

Person 1: I love you.

Person 2:

Person 1: Don't worry. It'll be okay.

Person 2:

Person 1: Just let me try this for a little bit.

Person 2:

Person 1: Whats the big deal? We've done this before.

Person 2:

Person 1: Well, I just don't want to stop. It's too much fun.

Person 2:

Person 1: Okay. I promise we'll stop after this.

Person 2:

Person 1: Other people have let me.

Person 2:

CONVERSATION STARTERS

Directions: Cut each of the sentences into strips so there is only one "line" per strip. Put all of the strips into a small paper lunch bag or plastic sandwich bag and use with the *Setting Sexual Limits Worksheet* to create a conversation about setting sexual limits.

I really like you.

I really like being with you.

I'm so glad that we're going out.

I really like kissing you.

I feel really special when you are kissing me.

I really liked what we did last night.

Me, too.

You're a great kisser.

I feel really close to you, too.

I think I'd like us to do more.

I think we should go further.

You can trust me.

I'm not comfortable doing more than kissing.

I'm scared we'll want to go further.

I'm scared we won't be able to stop.

But we've been going together for awhile.

But everyone else is doing this.

But I'm tired of stopping myself.

Please don't put pressure on me.

I'm really serious—I just want to make out.

Don't you like kissing me? I really enjoy it when we make out.

Okay... Let's stop talking and get started.

I do really like you... We won't go further until you're ready.

Sure...if that's what you want. But I don't promise not to ask again.

SETTING SEXUAL LIMITS WORKSHEET

Directions: Create a conversation about setting sexual limits between the couple in the picture. To begin the conversation, pick one of the opening lines from the list the class brainstormed. Next, create the conversation using only "lines" you have picked from those in the bag you were given. The conversation must come out okay for both partners, and they can't break up.

OPENING LINE:

PERSON 1:

PERSON 2:

PERSON 1:

PERSON 2:

PERSON 1:

PERSON 2:

PERSON 1:

PERSON 2:

PERSON 1:

PERSON 2:

Safe Sex Myths

MYTH: You can't get pregnant the first time you have sex. It may seem like the odds are in your favor, but there's no reason to risk it: You are just as likely to get pregnant the first time you have sex as any other.

MYTH: You can't get pregnant during your period. It is unlikely, but still possible—especially if you're not using a condom or birth control. Some women have long periods that overlap with the beginning of ovulation, which means they can be fertile even though they're menstruating.

MYTH: The "morning after" pill causes an abortion. Plan B, also known as the "morning after" pill, is not the same as RU-486, a pill that causes an abortion. In fact, if you take Plan B when you're already pregnant—that is, if a fertilized egg has attached to the wall of your uterus—it won't make a bit of difference. Emergency contraception CANNOT work if *conception* has already occurred: pregnancy is not instant, it takes some time, and that's why after 120 hours, EC is unlikely to work. EC works by preventing pregnancy, right from the start -- by keeping an egg from being released and/or changing the environ of the *vagina* to make it tougher for *sperm* to move -- not by terminating an existing pregnancy.

MYTH: Birth control pills make you gain weight. Although clinical trial after clinical trial has been unable to prove a correlation between oral contraceptives and weight gain, this is still a common belief among women of all ages. Specifically, a review article published in 2006 analyzed 44 previous trials and found that while some participants did gain weight during their studies, there was no evidence that their birth control was to blame.

MYTH: Condoms equal safe sex. *Condoms might make sexual activity safer, but they are not safe.* User error is the number one reason a condom will fail, which could result in pregnancy or STI transmission. Learn how to properly put on and wear a condom during sexual activity. This is important for both men and women to learn. An additional form of birth control increases the protection against pregnancy when wearing a condom.

MYTH: Using two condoms is safer than using one because if one breaks you'll still be protected. Actually, using two condoms rather than one increases friction between them during sex and can cause both of the condoms to tear or break. Condoms by themselves are 98% effective with perfect use and 85% effective with typical use. If you want to take some extra precautions or feel that condoms are not effective enough by themselves then it's best to look for another good method of birth control and use condoms as your back-up method.

MYTH: Condoms take away all feeling for men and thus ruin sex. Condoms are a thin piece of material. Using thinner condoms is safer because thicker made condoms can create more friction and actually cause them to break. Condoms don't cause men to lose all feeling during sex, the change is actually minimal. Many men actually state that condoms help them feel better during sex. Using condoms can help both partners to be more relaxed by reducing pregnancy risks.

MYTH: Anal sex prevents pregnancy. Sperm are live and mobile, and as such, any ejaculation near the vaginal opening, even mutual masturbation resulting in ejaculate on the woman's body near the vaginal opening, can result in pregnancy. While it is rare that this would occur, it's important to note that it can occur. Always wear or insist your partner wear a condom as well as an alternate form of birth control to prevent pregnancy, regardless of whether the sexual activity is masturbatory, anal or vaginal if ejaculate comes anywhere near the woman's body.

MYTH: Oral sex is safe sex. *While strictly engaging in oral sex will not result in pregnancy, sexually transmitted diseases can still be transmitted via oral sex.* Oral sex still requires fluid contact between the mouth and genitals, and any sexually transmitted disease one partner might have can indeed be transmitted during oral sex, even HIV. Use the same precautions with oral sex as penetrative sex.

MYTH: Pulling out is safe. *Men secrete fluid even prior to ejaculation, and the vaginal lining excretes fluid as well, particularly during arousal. When a person comes into contact with body fluids, STDs can be transmitted, even if the man pulls out before full ejaculation. Additionally, pregnancy can still occur, since sperm is still present in pre-ejaculate.* Always wear a condom during penetrative and oral sex to hinder disease transmission and help prevent pregnancy.

MYTH: Douching after sex is a good idea because you can wash away sperm and bacteria. This method of “freshening” the vagina and preventing pregnancy is one method that has been proven a bad idea again and again. The vagina has its own way of cleaning out bacteria—vaginal secretions. There is a natural acidic ph balance maintained in the vagina, and the good bacteria help to ward off infections.

Sources:

- http://www.scarleteen.com/article/body/misconception_mayhem_separating_myths_from_facts
- http://www.health.com/health/gallery/0,,20307293_1,00.html
- http://www.associatedcontent.com/article/533035/myths_about_safe_sex_and_recommendations.html?cat=41

Contraceptive Choices

Method	How it works	Effectiveness	Advantages	Possible problems
Continuous Abstinence	Not having oral, anal, or vaginal contact with a partner. Prevents sexual body fluid contact, which prevents pregnancy and STIs.	100% effective against pregnancy and STIs.	No medical or hormonal side effects. No risk of infection or unintended pregnancy.	May be difficult to abstain from sex for long periods of time; may be unprepared to use protection when abstinence ends.
Condom	Following package instructions, place over penis before intercourse to create a barrier; prevents sperm from joining egg.	86-98% effective. Some protection from STIs.	Provides some protection from infection and pregnancy; available at many locations. Sold over the counter.	Latex allergies; polyurethane condoms available; breakage due to user error.
Spermicide (foam, cream, jelly, film, sponge, suppository)	Following package instructions, apply before intercourse. Immobilizes sperm to prevent them from joining egg.	50-94% effective. No protection from STIs.	Sold over the counter.	Can be messy; using product with nonoxynol-9 more than three times a day may be irritating.
Female Condom (Reality®)	Inserted into vagina to create a barrier; prevents sperm from joining egg.	79-95% effective. Some protection from STIs.	Provides some protection from infection and pregnancy; sold over the counter; can be used by people allergic to latex.	May be noisy and may be difficult to insert.
Diaphragm or Cervical Cap	Inserted into vagina to create a barrier, preventing sperm from joining egg.	80-94% diaphragm. 60-90% cervical cap. No protection from STIs.	No major health concerns; no hormonal side effects; method can last several years.	Must be put in place before intercourse; can be messy; can be difficult to fit; latex allergies.
Sterilization (Vasectomy or Tubal Ligation)	An operation that permanently blocks either a man's tubes that carry sperm or a woman's tubes where a sperm fertilizes an egg.	95.5-99.9% effective. No protection from STIs.	Permanent protection against pregnancy, no effect on sexual pleasure, and protects women whose health could be threatened by pregnancy.	Risks of min or surgery; not usually reversible.
Fertility Awareness Method	Checking temperature and cervical mucus daily to attempt to predict ovulation.	75-99% effective. No protection from STIs.	No medical or hormonal side effects.	Ovulation is difficult to predict. Precise record keeping necessary. Requires periods of abstinence.
The Pill	Take a pill each day. Prevents release of egg, thickens cervical mucus and prevents implantation of fertilized egg.	95-99% effective. No protection from STIs.	Nothing to put in place before intercourse. Less cramping, may regulate periods, protects against some cancers.	Must be taken daily at the same time each day. Irregular bleeding and breast tenderness.

Contraceptive Choices

Birth Control Shots (Depo-Provera®)	Injection once every three months. Prevents release of egg, thickens cervical mucus and prevents implantation of a fertilized egg.	99.7% effective. No protection from STIs.	No daily pill; reduces cramps; nothing to put in place before intercourse; protects against some cancers.	Loss of monthly period, irregular bleeding, depression, increased appetite, change in sex drive. May cause delay in getting pregnant after shots are stopped. Recommended for 2 year use because it can decrease bone density.
The Ring (Nuva Ring®)	Insert into the vagina once a month. Prevents release of egg, thickens cervical mucus and prevents implantation of a fertilized egg.	95-99% effective. No protection from STIs.	No daily pill; does not require a "fitting" by a health care provider.	Increased vaginal discharge, vaginal irritation, may be uncomfortable for some women to insert
The Patch (Ortho Evra®)	Apply a new patch each week. Prevents release of egg, thickens cervical mucus and prevents implantation of a fertilized egg.	95-99% effective. No protection from STIs.	No daily pill.	Skin reactions at site of application, breast tenderness.
Implanon	Inserted under the skin of arm by a health care provider, effective for 3 years. Prevents release of egg, thickens cervical mucus and prevents implantation of a fertilized egg.	99% effective. No protection from STIs.	Nothing to put in place before intercourse; lasts for 3 years.	Irregular bleeding, possible loss of periods. Must be implanted/removed by a health care provider.
Intra-uterine system (IUS) (Mirena®) Intra-uterine device (IUD) (Paragard®)	Inserted into the uterus by a health care provider. Device containing progesterone hormones, prevents release of egg, thickens cervical mucus, and prevents the implantation of a fertilized egg.	97-99% effective. No protection from STIs.	No daily pill; nothing to put in place before intercourse, IUS may reduce menstrual cramps and bleeding, may be left in place for up to 5 yrs; IUD has no hormonal side effects, may be left in place for up to 12 yrs.	Possible spotting between periods, Possible displacement. IUS very light or no periods. IUD increase in cramps, heavier and longer periods.
Emergency Contraception Pills (Plan B®)	Two pills taken together. Prevents release of egg, thickens cervical mucus and prevents implantation of a fertilized egg if taken up to 120 hrs after unprotected sex.	75-89% effective. No protection against STIs.	Can be used if primary birth control failed or if you had unprotected sex.	Only effective for the most recent act of unprotected intercourse. More effective when the first dose is taken within 72 hours.

Sexually Transmitted Infections

Infection	Possible symptoms	Transmission	Diagnosis/Treatment	Possible Complications
Chlamydia	No Symptoms. Discharge from penis, vagina, or anus. Pain or burning with urination. Pain or bleeding with intercourse. Nausea. Abdominal pain. Pain or swelling in testicles.	Anal, oral, or vaginal intercourse. Direct contact between open mucus membranes. Mother to child.	Culture of discharge from infected area. Urine testing. Curable with antibiotics. All partners must be treated at the same time.	Painful swelling of the testicles in men or pelvic inflammatory disease (PID) in women. Possible infertility. Blindness in infants.
Gonorrhea	No Symptoms. Discharge from penis, vagina, or anus. Pain or burning with urination. Abdominal pain. Rectal pain. Sore throat if orally contracted.	Anal, oral, or vaginal intercourse. Direct contact between open mucus membranes. Mother to child.	Culture of discharge from infected area. Urine testing. Curable with antibiotics. All partners must be treated at the same time.	Urethral and erectile dysfunction in men or pelvic inflammatory disease (PID) in women. Possible infertility. Blindness in infants.
Pelvic Inflammatory Disease (PID)	Longer, heavier and more painful periods. Lower abdominal pain. Nausea. Vomiting. Fever. Sweats. Chills. Fatigue. Discharge. Pain with intercourse.	Secondary infection that may result from an untreated STI or vaginal infection in women.	Clinical evaluation of symptoms. Curable with antibiotics, bed rest and (in some cases) surgery and/or hospitalization.	Possible infertility. Ectopic or tubal pregnancy.
Syphilis	Primary Phase: Painless sore called a <i>chancre</i> may appear 10-90 days after exposure. Secondary Phase: Swelling of lymph nodes. Body rashes. Fatigue. Hair and weight loss. Symptoms may come and go for up to 2 years. Latent Phase: No symptoms. Tertiary Phase: Damage to nervous system and organs. Disfigurement.	Anal, oral or vaginal intercourse. Direct contact with rashes or chancres. Mother to child.	Blood test. Curable with antibiotics. Secondary symptoms may need additional treatment. All partners must be treated at the same time.	Excess tissue growths and skin disfigurement. Damage to brain, heart, eyes, teeth, lungs, and nervous system. Psychosis. Paralysis. Death.
Trichomoniasis (Trich)	No Symptoms. Frothy, fishy smelling discharge. Vaginal itching. Pain with urination or intercourse.	Anal, oral or vaginal intercourse.	Microscopic examination of infected discharge. Curable with antibiotics. All partners must be treated at the same time.	Untreated pregnant women have increased risk for premature birth or lower weight babies. Irritation of the prostate in men.
Public Lice (Crabs)	No Symptoms. Intense itching and/or bumps in pubic area. Can live in anal hair, eyelashes, eyebrows and armpits.	Direct contact with infected person or object such as bedding or clothing.	Visual inspection. Over the counter lotions and thorough cleaning of clothes and living space.	Scarring can occur from scratching.

Sexually Transmitted Infections

Infection	Possible symptoms	Transmission	Diagnosis/Treatment	Possible Complications
Scabies	No Symptoms. Intense itching and rash caused by scabies leaving fecal trails under the skin. Rashes may appear as intricate patterns between the fingers and spread to other parts of the body.	Direct contact with infected person or object such as bedding or clothing.	Visual inspection and/or microscopic examination of skin scraping. Prescription lotions and thorough cleaning of clothes and living space.	Scarring can occur from scratching.
Human Papilloma Virus (HPV) or Genital Warts	No Symptoms. Flesh colored bumps can appear in genitals, cervix, anus, urethra or throat. Warts can be soft, hard, flat, raised, single or in clusters.	Direct skin-to-skin contact with infected person. Mother to child.	Visual inspection or pap smear. Treatment includes freezing, burning, or applying prescription medications to infected area(s).	There are 120 different strains of the virus. Warts can block throat, urethra, anus or the vaginal opening. May lead to cancer of the cervix, penis or vulva.
Herpes Simplex Virus I & II (HSV)	No Symptoms. Fluid filled sores, blisters or bumps may appear in mouth or genitals 2-21 days after exposure. The sores may itch, burn, tingle or cause pain. Flu like symptoms may occur.	Direct skin-to-skin contact with an infected person. Mother to child. Type I is most often an oral infection or cold sore. Type II is most often found in the genital area.	Visual inspection or culture of fluid from sore. Sores must be present to diagnose. Treatment includes prescription medications to reduce frequency and lengths of outbreaks. Healthy lifestyle encouraged. No cure.	Open sores may make a person more susceptible to HIV transmission.
Hepatitis B (HBV)	No Symptoms. Weight and/or hair loss. Nausea. Vomiting, joint pain. Fatigue. Yellowing of the skin and eyes (jaundice).	Anal, oral or vaginal intercourse. Blood-to-blood contact. Mother to child.	Blood test. Vaccine available to prevent HBV. Chronic carriers may need to seek medical treatment. No cure.	Liver damage, failure, and/or cancer. Death.
Human Immunodeficiency Virus (HIV)	May have flu like symptoms at onset of infection but generally no symptoms.	Anal, oral or vaginal intercourse. Blood-to-blood contact. Mother to child.	Blood or urine test, oral swab. Healthy lifestyle encouraged and treatment available. No cure.	Opportunistic infections which can lead to Acquired Immunodeficiency Syndrome (AIDS). Hospitalization. Death.

A BASIC SAFER SEX KIT

should contain the following:

- Condoms (unlubricated or lubricated)
- Lubricant (latex-safe, water or silicone based, and should indicate for sexual/genital use on bottle)
- Latex gloves (or nonlatex for those with allergies)
- Dental dams (or a small scissors for cutting condoms or gloves to use as dams)
- Baby wipes (for quick cleanup of genitals, especially after using flavored lubes or condoms or silicone lubricants)
- An over-the-counter analgesic, such as aspirin, acetaminophen, or ibuprofen (helpful for soreness due to vasocongestion aka "blue balls")
- Aloe vera gel (handy for external genital irritation after sexual activities)



If you can't afford the basic supplies, you can't afford to be sexually active. Safer sex gear is going to be the least of your expenses, and it's worth the expense up front to protect yourself in the long run.

COMMON CONDOM REFUSALS WORKSHEET

INSTRUCTIONS FOR THE FACILITATOR

Cut out each refusal. Paste it on an index card or copy it onto a blank sheet of paper. Give each small group one or more refusals. Small groups may use the *Condom-Friendly Responses Worksheet*. They should, however, make up at least one response on their own.

Refusal

"Don't worry I'll pull out before I come."

1. _____
2. _____
3. _____

Refusal

"It will feel better if we don't use a condom."

1. _____
2. _____
3. _____

Refusal

"It will interrupt the mood if we have to stop and put on a condom."

1. _____
2. _____
3. _____

Refusal

"I don't have a condom with me and I want to have intercourse now."

1. _____
2. _____
3. _____

Refusal

"I don't want anything between us."

1. _____
 2. _____
 3. _____
-

CONDOM-FRIENDLY RESPONSES WORKSHEET

- A.** "Let's go get some together."
- B.** "I care about us too much to put either one of us at risk."
- C.** "There are lots of ways to make each other feel good without having to use a condom."
- D.** "You are important to me and I want us to be safe."
- E.** "If we use the condom we don't have to worry about it at all."
- F.** "If we use the condom I'll be more relaxed and I'll enjoy myself more."
- G.** "When we're dressed and I hug you, it feels special. So how can a little piece of latex or polyurethane ruin it."
- H.** "The condom can make you last longer."
- I.** "I can't enjoy intercourse unless we use a condom."
- J.** "Let's not have intercourse. We can do other things to be close."

Sexual Assault and Rape Myths

MYTH: Sexual assault is an impulsive, uncontrollable act of passion. The victim is irresistible to the rapist.

Rape is an act of violence, not of sexual desire. The majority of rapes are planned: the place arranged, enticement used, or the victim deliberately sought and coerced into sexual relations. It is the vulnerability of the victim that attracts the sexual predator. Victims range from infants to the elderly. Anyone, regardless of age, sex, physical appearance, marital status, ethnic, religious or socio-economic background can be raped.

MYTH: Most rapists hide in dark alleys, waiting for a stranger to walk past.

The majority of reported rapes occur either in the victim's home or the home of the attacker. In many cases, the victim met the offender in a public place and then was coerced into accompanying the rapist to the place of the assault. Most rape victims know their attacker at least casually. In many cases, offenders were well known to the victim and were in relationships that one would normally trust, i.e. boyfriend, family friend, close neighbor or relative.

MYTH: Most rapists are poor.

Rape crosses all class lines. People have been raped by doctors, lawyers, police officers, and other authority figures. Because of their social and financial positions, these offenders are seldom prosecuted for the acts of violence, and their actions are seldom publicized.

MYTH: No person can be sexually assaulted against his or her will.

Rape is a crime of violence, not sexual passion. In many cases, some type of force is used, such as choking, beating, roughness, or use of a weapon. Often, the victim is threatened with death if he or she resists. Confronted with the fear of being beaten or killed, many victims do not attempt to fight an attacker. While a victim may not resist an attack due to socialization and fear of violence, this lack of resistance should not be equated with consent for the attack. Many mugging victims hand over their wallets willingly to maintain their safety, but they did not ask to be mugged.

MYTH: Sexual assault is provoked by the victim. Victims ask for it by their actions, behaviors, or by the way they dress.

Fact: To say that someone wants to be raped is the same as saying that people ask to be mugged or robbed. In fact, most rapes are at least partially planned in advance and the victim is often threatened with death or bodily harm if he or she resists. Sexual assault is not a spontaneous crime of sexual passion. It is a violent attack on an individual using sex as a weapon. Sex is used to defile, degrade and destroy a victim's will and control over his or her own body. For the victim, it is a humiliating, near death situation. No person would ask for or deserve such an attack.

MYTH: Only "bad girls" get sexually assaulted.

Sexual assault occurs in all segments of our society. Most rapists choose their targets without regard to physical appearance or lifestyle. Victims are of every type, race, and socio-economic class, young and old alike.

MYTH: Most rapes are reported by women who "change their minds" afterwards or who

want to “get even” with a man.

FBI statistics show that only 3% of rape calls are false reports. This is the same false-report rate that is usual for other kinds of felonies.

MYTH: Rapists are crazy, deranged, abnormal perverts. They are lonely men without female partnership.

Rape is not a crime of spontaneous passion. Studies show that 60 to 70% of all sexual assaults are planned. Most rapists are married and having consensual sexual relations while assaulting other women. Rapists themselves do not describe their motivation in terms of sexual gratification, but in terms of hatred and conquest. Sex is used as a weapon to inflict violence, humiliation, and degradation on a victim. Indeed, rapists have said that rape is “lousy sex.” Sexual offenders come from all educational, occupational, racial and cultural backgrounds. They tend to test differently from the normal, well-adjusted male only in having a greater tendency to express violence and rage.

MYTH: Men cannot be raped.

Sexual assault, no matter the gender of the perpetrator or victim, is a form of violence where sex is used to demean and humiliate another person. Current statistics indicate that one in six men are sexually assaulted or abused in their lifetime. Typically, the perpetrator is a heterosexual male. Sexual assault of males is thought to be greatly underreported.

MYTH: A man can't rape his wife.

Many states now have laws against rape in marriage. The idea that a man can't rape his wife suggests married women do not have the same right to safety as do unmarried women. Most battered women have experienced some form of sexual abuse within their marriage. It is also known that estranged or ex-spouses sometimes use rape as a form of retaliation.

MYTH: Sexual assaults are rare deviations and affect few people. After all, no one I know has been raped.

Sexual assaults are very common. Most likely, someone close to you has been profoundly affected by sexual assault. Not only are victims reluctant to discuss their assaults but many succeed in **totally blocking the assault** from conscious memory. However, the trauma remains and may come to the surface at another crisis or when the opportunity to discuss it with a sympathetic person arises.

Sources:

http://www.ccasa.org/documents/Rape_Myths_&_Facts.pdf

<http://www.d.umn.edu/cla/faculty/jhamlin/3925/myths.html>

"The Rape of Mr. Smith"

The law discriminates against rape victims in a manner that would not be tolerated by victims of another crime. In the following example, a holdup victim is asked questions similar in form to those usually asked a victim of rape.

Officer: "Mr. Smith, you were held up at gunpoint on the corner of 16th and Locust?"
 Mr. Smith: "Yes."
 Officer: "Did you struggle with the robber?"
 Mr. Smith: "No."
 Officer: "Why not?"
 Mr. Smith: "He was armed."
 Officer: "Then you made a conscious decision to comply with his demands rather than to resist?"
 Mr. Smith: "Yes."
 Officer: "Did you scream? Cry out?"
 Mr. Smith: "No, I was afraid."
 Officer: "I see. Have you ever been held up before?"
 Mr. Smith: "No."
 Officer: "Have you ever given money away?"
 Mr. Smith: "Yes, of course..."
 Officer: "And you did so willingly?"
 Mr. Smith: "What are you getting at?"
 Officer: "Well, let's put it like this, Mr. Smith. You've given away money in the past... in fact, you have quite a reputation for philanthropy. How can we be sure that you weren't contriving to have your money taken from you by force?"
 Mr. Smith: "Listen, if I wanted..."
 Officer: "Never mind. What time did this holdup take place, Mr. Smith?"
 Mr. Smith: "About 11 p.m."
 Officer: "You were out on the street at 11 p.m.? Doing what?"
 Mr. Smith: "Just walking."
 Officer: "Just walking? You know that it's dangerous being out on the street that late at night. Weren't you aware that you could have been held up?"
 Mr. Smith: "I hadn't thought about it."
 Officer: "What were you wearing at the time, Mr. Smith?"
 Mr. Smith: "Let's see. A suit. Yes, a suit."
 Officer: "An expensive suit?"
 Mr. Smith: "Well...yes."
 Officer: In other words, Mr. Smith, you were walking around the streets late at night in a suit that practically advertised the fact that you might be a good target for some easy money, isn't that so? I mean, if we didn't know better, Mr. Smith, we might even think that you were asking for this to happen, mightn't we?"
 Mr. Smith: "Look, can't we talk about the past history of the guy who did this to me?"
 Officer: "I'm afraid not, Mr. Smith. I don't think you would want to violate his rights, now would you?"

Taken from the American Bar Association Journal

Naturally, the line of questioning, the innuendo, is ludicrous -- as well as inadmissible as any sort of cross examination -- unless we are talking parallel questions in a rape case. The time of night, the victims' previous history of "giving away" what was previously taken by force, the clothing -- all these are held against the victim. Society's posture on rape, and the manifestation of that posture in the courtroom, account for the fact that so few rapes are reported.

What is “enthusiastic consent”?

The concept of "enthusiastic" consent challenges the notion that a sexual assault victim should be responsible for preventing rape and instead puts the onus on both parties to initiate sexual contact only when a partner affirmatively expresses desire. Silence, in other words, is not consent.

The enthusiastic consent model makes the person who initiates physical contact responsible, regardless of gender, for fighting against the culture of victim blaming. Under this model, the person initiating contact is required to take account of and not exploit a relationship, the other person's intoxicated state, or the power of peer pressure or social conditioning. No matter what the type of contact, the initiating party must get genuine consent. It is not acceptable to touch another person who has not given affirmative permission, no matter how harmless it seems to the one doing the touching.

The enthusiastic consent model encourages members of both sexes to speak up about desires. Not only should the parties consent only to touch that they really want, but they should also affirmatively communicate about sex. The idea is that if a culture of open communication develops, there will be less of a risk of unwanted touching short of rape, of misunderstandings or unreasonable expectations that sometimes result in "date" rape, or of consent based on societal expectation rather than desire. This model would also destigmatize "no," so that individuals will not feel guilty about refusing touch and those initiating touch will not experience embarrassment or loss of pride when an offered touch is refused.

Sources:

<http://www.suite101.com/content/using-enthusiastic-consent-to-fight-rape-culture-a96089>

Yes Means Yes: Visions of Female Sexual Power and a World Without Rape,
Jaclyn Friedman and Jessica Valenti eds. (Seal 2008)

"NO" Means "NO"

"NO" means NO.

"Not Now" means NO.

"Maybe Later" means NO.

"I Have A Boy/Girlfriend" means NO.

"No Thanks" means NO.

"You're Not My Type" means NO.

"*#^+ Off!" means NO.

"I'd Rather Be Alone Right Now" means NO.

"Don't Touch Me" means NO.

"I Really Like You But ..." means NO.

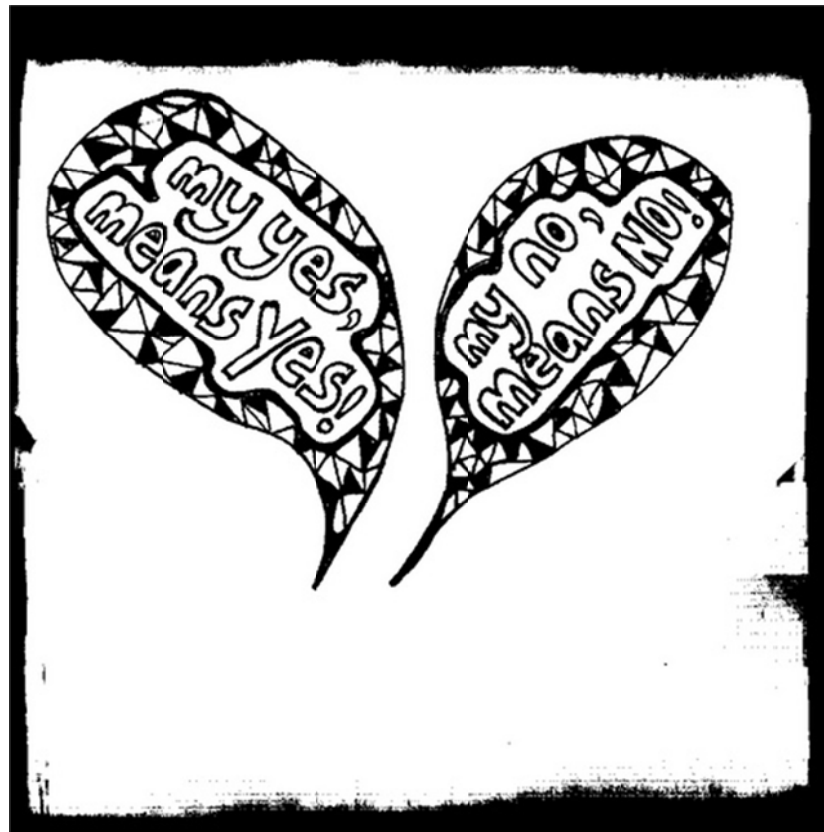
"Let's Just Go To Sleep" means NO.

"I'm Not Sure" means NO.

"You've/I've Been Drinking" means NO.

SILENCE means NO.

" _____ " means NO.



What YOU can do to prevent unwanted sexual experiences:

- **Know your boundaries.** Decide before you head out for the night how far you're willing to go with your partner. Is the kiss at the end of the night enough or are you ready to head back to someone's house for more? It's easier to stick to decisions you've made before alcohol and the spirit of the night carries you away. Don't be afraid to make your intentions known before the evening gets underway - your partner will respect you more for being firm in your choices.
- **If you're going to drink, be responsible** - make sure you have a designated driver or chip in for a group cab. Don't accept a drink from anyone you don't know and never leave it unattended.
- **Use the buddy system:** Go to parties or bars in groups. This way you can keep an eye on one another, each others' dates, and each others' drinks. If a friend starts showing symptoms that go beyond buzzed - nausea, dizziness, hallucinations, loss of consciousness - seek medical attention immediately and tell the EMS you suspect she(or he) may have ingested a date rape drug.
- **Keep in touch.** If you plan to hop from bash to bash, make sure you leave each location with the same crew you arrived with. Never leave a friend (or even a friend and her date) alone at a party. Keep in touch by text to see when people are ready to go.

The Big Picture:

- **Speak up.** You will probably never see a rape in progress, but you will see and hear attitudes and behaviors that degrade women and promote rape. When your best friend tells a joke about rape, say you don't find it funny. When you read an article that blames a rape survivor for being assaulted, write a letter to the editor. When laws are proposed that limit women's rights, let politicians know that you won't support them. Do anything but remain silent.
- **Contribute your time and money.** Join or donate to an organization working to prevent violence against women. Rape crisis centers, domestic violence agencies, and men's anti-rape groups count on donations for their survival and always need volunteers to share the workload.
- **Talk with women...** about how the risk of being raped affects their daily lives; about how they want to be supported if it has happened to them; about what they think men can do to prevent sexual violence. If you're willing to listen, you can learn a lot from women about the impact of rape and how to stop it.
- **Talk with men...** about how it feels to be seen as a potential rapist; about the fact that 10-20% of all males will be sexually abused in their lifetimes; about whether they know someone who's been raped. Learn about how sexual violence touches the lives of men and what we can do to stop it.
- **Organize.** Form your own organization focused on stopping sexual violence. Anti-rape groups are becoming more and more common around the country, especially on college campuses. If you have the time and the drive, it is a wonderful way to make a difference in your community.

How to support a survivor

- **Educate yourself about rape.**
- **Believe them.** Less than 1/10 rape accusations are false, and a large percentage goes unreported. If someone tells you they were raped or sexually assaulted, ALWAYS assume they are telling the truth.
- **Encourage them to seek medical attention.** Rape victims will not be forced to press charges against their assailants, but they may have internal injuries and should always ask for a rape kit.
- **Allow them to make their own choices.** Survivors need to regain a sense of control over their life.

What not to say:

- “What were you wearing?”
- “Were you drinking?”
- “Did you know the person?”
- These things don’t matter, and will make the survivor feel responsible for the crime.

What you can say:

- “You’re alive—that’s all that matters. You didn’t do anything wrong. You did a lot of things RIGHT—You survived!”
- “I don’t think any less of you because of this.”
- “It was not your fault. You don’t deserve this.”
- “You don’t have to share your feelings with me, but I’ll listen to them if you want me to.”
- “You don’t have to worry about me or take care of my feelings.”
- “I’ll never know how you feel, but I can see you’re hurting. I understand you may not want to be touched.”
- “I will leave when you want to be alone. I’ll be here when you want me here.”

USU Campus & Community Resources

SAAVI: Sexual Assault and Anti-Violence Information - <http://www.usu.edu/saavi>

- Help create violence-free environments and healthy relationships at USU
- Provide help to anyone who experiences violence
- Offer support to victims of sexual assault, rape, dating violence, domestic violence, and stalking.

CAPSA: Community Abuse Prevention Service Agency—<http://www.capsa.org>

- Provide services to any victim of domestic violence or sexual assault, men or women, including men and women in same-sex relationships.

Questions in general...

[Amplify Your Voice](http://amplifyyourvoice.org). amplifyyourvoice.org
[Go Ask Alice](http://goaskalice.columbia.edu). goaskalice.columbia.edu
[I Wanna Know](http://iwannaknow.org). iwannaknow.org
[Sexual Health Network](http://sexualhealth.com). sexualhealth.com
[Sex, etc.](http://sexetc.org) sexetc.org
[Scarleteen](http://scarleteen.com). scarleteen.com
[Stay Teen](http://stayteen.org). stayteen.org

Anatomy, Sexual Response, and Safe Sex Practices

[Ann Rose's Ultimate Birth Control Links](http://ultimatebirthcontrol.com). ultimatebirthcontrol.com
[Condomania](http://condomania.com). condomania.com
[Our Bodies, Ourselves](http://ourbodiesourselves.com). ourbodiesourselves.com
[Planned Parenthood](http://plannedparenthood.org). plannedparenthood.org

Communication and Preventing Unwanted Experiences

[The Consensual Project](http://theconsensualproject.com). theconsensualproject.com
[Love is Respect](http://loveisrespect.org). loveisrespect.org
[Men Can Stop Rape](http://mencanstoprape.org). mencanstoprape.org
[National Sexual Violence Resource Center](http://nsvrc.org). nsvrc.org
[Promoting Awareness Victim Empowerment](http://pavingtheway.net). pavingtheway.net
[Rape, Abuse, and Incest National Network](http://rainn.org). rainn.org
[Where Is Your Line?](http://whereisyourline.org) whereisyourline.org
[Yes Means Yes Blog](http://yesmeansyesblog.wordpress.com). yesmeansyesblog.wordpress.com

Lesbian, Gay, Bisexual, Transgender, and Queer Information

[American Civil Liberties Union](http://aclu.org/lgbt-rights). aclu.org/lgbt-rights
[Gay, Lesbian and Straight Education Network](http://glsen.org). glsen.org
[Youth Resource](http://www.amplifyyourvoice.org/youthresource). www.amplifyyourvoice.org/youthresource

Education, Advocacy, and Research

[Advocates for Youth](http://advocatesforyouth.org). advocatesforyouth.org
[The American Social Health Association](http://ashastd.org). ashastd.org
[The Center for Reproductive Rights](http://reproductiverights.org). reproductiverights.org
[The Guttmacher Institute](http://guttmacher.org). guttmacher.org
[The Kaiser Family Foundation](http://kff.org). kff.org
[The Sexuality Information and Education Council of the U.S.](http://siecus.org) siecus.org

USU Resources

[USU Sexual Assault and Anti-Violence Information](http://usu.edu/saavi). usu.edu/saavi
[USU Counseling and Psychological Services](http://usu.edu/counseling). usu.edu/counseling
[USU Student Health & Wellness Center](http://usu.edu/health). usu.edu/health

Appendix E
Group Fidelity Checklist

Session 1: Introductions, Anatomy and Sexual Response

Module	Time	Covered	Engagement Rating (1-5)
Leader/member introductions, process metaphor, group orientation	10 min	Y N	
Discussion of values, educational history, family/peer attitudes	20 min	Y N	
Slang terms ice-breaker	10 min	Y N	
Anatomy worksheets	15 min	Y N	
Human sexual response handout and discussion	20 min	Y N	
Discuss material, address further questions	13 min	Y N	
Introduce next session's topic (anonymous feedback form)	2 min	Y N	n/a

Participant Participation Rating

Participant	Present	Verbal Engagement Rating	Non-Verbal Engagement Rating	Notes
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Engagement Rating Scale:

Passive Disengaged 1 2 3 4 5 Active Highly Engaged

Session 2: Communication

Module	Time	Covered	Engagement Rating (1-5)
Review previous session's discussion	5 min	Y N	
Reasons for communication pros and cons discussion (if participants are reluctant to engage, more discussion will occur concurrent with handout)	30 min	Y N	
Effective Communication handout discussion (this will take more or less time depending on how many of the points came up in the discussion above)		Y N	
Conversation role play (10 min/role play, 20 min for discussion). If this activity does not seem to "click" for the group, fill this time with different exercises listed in "supplemental activities."	40 min	Y N	
Discuss material, address further questions	13 min	Y N	
Introduce next session's topic (anonymous feedback form)	2 min	Y N	n/a

Participant Participation Rating

Participant	Present	Verbal Engagement Rating	Non-Verbal Engagement Rating	Notes
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Engagement Rating Scale:

Passive Disengaged 1 2 3 4 5 Active Highly Engaged

Session 3: Safer Sex Practices

Module	Time	Covered	Engagement Rating (1-5)
Review previous session's discussion	5 min	Y N	
Discuss myths about safer sex (handout)	30 min	Y N	
STI prevention discussion (handout)		Y N	
Pregnancy prevention discussion (handout)		Y N	
Basic safer sex kit handout and demonstration	15 min	Y N	
Supplemental worksheets and role plays	25 min	Y N	
Discuss material, address further questions	13 min	Y N	
Introduce next session's topic (anonymous feedback form)	2 min	Y N	n/a

Participant Participation Rating

Participant	Present	Verbal Engagement Rating	Non-Verbal Engagement Rating	Notes
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Engagement Rating Scale:

Passive Disengaged 1 2 3 4 5 Active Highly Engaged

Session 4: Preventing Unwanted Experiences

Module	Time	Covered	Engagement Rating (1-5)
Review previous session's discussion	5 min	Y N	
What is an unwanted experience? Who is responsible? Discussion (Myths)	15 min	Y N	
Enthusiastic consent vs. no means no	5 min	Y N	
Prevention and support	10 min	Y N	
Discuss material, address final questions, end of group, and goodbyes	30 min	Y N	
Distribute resources guide	2 min	Y N	n/a
Complete posttest inventories	25 min	Y N	n/a

Participant Participation Rating

Participant	Present	Verbal Engagement Rating	Non-Verbal Engagement Rating	Notes
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Engagement Rating Scale:

Passive Disengaged 1 2 3 4 5 Active Highly Engaged

Appendix F
Demographic Survey

About you:

Your birth date: Month _____ Year _____

Your class level (check one):

- Freshman Sophomore Junior Senior Graduate

What type of high school did you attend? (check one)

- Public Homeschooled
 Private Other (please describe)

Highest level of education completed by a parent/guardian whom you lived with (check up to two):

- Less than high school 4 year college degree (BA, BS)
 High school/GED Masters degree
 2 year college degree (Associates) Doctoral degree
 Professional degree (MD, JD)

Your ethnicity or race (check all that apply):

- Native American / American Indian Latino/a, Chicana/o or Hispanic
 Asian American Native Alaskan
 Black or African American White / Caucasian
 Pacific Islander

Your *family's* primary spiritual/religious beliefs:

- Latter Day Saints (LDS/Mormon)
 Protestant (ex. Baptist, Episcopalian, Methodist, etc.)
 Catholic
 Jewish
 Agnostic
 None
 Other (please describe) _____

Your *personal* primary spiritual/religious beliefs:

- Latter Day Saints (LDS/Mormon)
 Protestant (ex. Baptist, Episcopalian, Methodist, etc.)
 Catholic
 Jewish
 Agnostic
 None
 Other (please describe) _____

How important would you say that your spiritual/religious beliefs are to you? (circle one)

Not at all 1 2 3 4 5 6 7 8 9 10 Extremely important important

Your biological sex:

- Female
- Male
- Other _____

Your gender identity:

- Female
- Male
- Other _____

To whom are you sexually or romantically attracted?

- Only same sex attracted
- Mostly same sex attracted
- Equally same-sex and other-sex attracted
- Mostly other-sex attracted
- Only other-sex attracted
- Other _____

What label describes your sexual orientation?

- Heterosexual/Straight
- Bisexual
- Gay/Lesbian
- Queer
- Other (please specify) _____

Your relationship status (check one):

- Single, not dating
- Single, dating casually
- Dating exclusively
- Living with partner
- Married
- Other (please describe)

How many individuals have you had sexual intercourse with? _____

How many times per month do you usually engage in sexual intercourse? _____

How often do you experience orgasm during your sexual encounters (does not have to be sexual intercourse)? (% of the time) _____

Where in Cache Valley can you access reproductive health services (e.g. annual sexual health exams, birth control prescription, STI testing and treatment)?

Where in Cache Valley can you access birth control?

Where in Cache Valley can you acquire safer sex products, such as condoms?

Appendix G
Sex Education Inventory

Sex Education Inventory

The statements and questions that follow ask you to indicate your attitudes and experiences regarding sex education and sexual activities. Please read each item carefully and respond as indicated on the basis of your own true beliefs. Your responses will remain anonymous.

1. Circle the *one letter* identifying the person or persons who should have primary responsibility for teaching young people about sexual matters.
 - a. No one special
 - b. Friends
 - c. Young people should find out on their own
 - d. Teachers (content of schoolwork)
 - e. Physicians and/or nurses
 - f. Parents
 - g. Professional sex educators or counselors
 - h. Ministers, priests, or other religious leaders
 - i. Other (please specify) _____

Now complete items 2 through 5 by using the list in item 1. Write *one letter* to indicate who should have primary responsibility for teaching young people about each of the following:

2. Birth control _____
3. Recognizing and preventing Sexually Transmitted Infections (STIs) _____
4. Moral and ethical questions related to sex _____
5. Interpersonal relations and sexuality _____
6. Circle the *letter* beside your *one main source* of information about sex in general.

a. No source	h. Professional sex educator or counselor
b. Female friends	(including personnel at family planning clinic)
c. Male friends	i. Minister, priest, or other religious leader
d. Father	j. Media (radio, TV)
e. Mother	k. Reading on my own
f. Other family members	l. Teacher in school (content of schoolwork)
g. Physician and/or nurse	m. Other (Please specify) _____

Now complete items 7 through 10 by using the list in item 6. Write the *letter of the one main source* from which you learned most of what you know about each of the following:

7. Birth control _____
8. Recognizing and preventing Sexually Transmitted Infections (STIs) _____
9. Moral and ethical questions related to sex _____

10. Interpersonal relations and sexuality _____

11. Place an X next to all the following sex-related topics you have discussed with your parents at any time or studied in high school or college.

	Discussed with		Studied in	
	Father	Mother	High School	College
1. Personal Hygiene	_____	_____	_____	_____
2. Menstruation	_____	_____	_____	_____
3. Pregnancy and delivery	_____	_____	_____	_____
4. Intercourse	_____	_____	_____	_____
5. Birth control	_____	_____	_____	_____
6. Specific methods of birth control	_____	_____	_____	_____
7. Sexually Transmitted Infections (STIs)	_____	_____	_____	_____
8. Abortion	_____	_____	_____	_____
9. Orgasm	_____	_____	_____	_____
10. Masturbation	_____	_____	_____	_____
11. Homosexuality	_____	_____	_____	_____
12. What to do to prevent STIs	_____	_____	_____	_____
13. Where to go for help if you need birth control information	_____	_____	_____	_____
14. Where to go for help if you suspect STIs	_____	_____	_____	_____
15. What to look for in a mate	_____	_____	_____	_____
16. "How far to go" on a date	_____	_____	_____	_____

Please indicate your reaction to the following statements by circling the *one* most appropriate number.

1	2	3	4	5	6	7
Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Not sure	Somewhat satisfied	Satisfied	Very satisfied

12. How satisfied are you with the way(s) in which you found out most of what you know about things having to do with sex? 1 2 3 4 5 6 7

13. How satisfied are you with your current knowledge about things having to do with sex? 1 2 3 4 5 6 7

14. Would you handle your own children's sex education pretty much the same yours was handled? (Check *one*.)

Yes _____ No _____ Can't say _____

Please explain why or why not. _____

Appendix H
Sexual Socialization Instrument

Sexual Socialization Instrument

Below you will see five numbers corresponding to five choices. Choose the response that best describes your degree of agreement/disagreement with each statement. Write only one response for each statement. Because all responses will remain anonymous you can respond truthfully with no concerns about anyone connecting responses with individuals.

1 = Strongly agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

- _____ 1. My mother would have felt okay about my having sex with many people.
- _____ 2. I am uncomfortable around people who spend much of their time talking about their sexual experiences.
- _____ 3. My father would have felt upset if he'd thought I was having sex with many different people.
- _____ 4. Among my friends, men who have the most sexual experience are the most highly regarded.
- _____ 5. My friends disapprove of being involved with someone who was known to be sexually easy.
- _____ 6. According to my parents, having sexual intercourse is an important part of my becoming an adult.
- _____ 7. Most of my friends don't approve of having multiple sexual partners.
- _____ 8. My friends and I enjoy telling each other about our sexual experiences.
- _____ 9. My parents stress that sex and intimacy should always be linked.
- _____ 10. Most of my friends believe that you should only have sex in a serious relationship.
- _____ 11. Among my friends alcohol is used to get someone to sleep with you.
- _____ 12. My parents would disapprove of my being sexually active.
- _____ 13. My friends approve of being involved with someone just for sex.
- _____ 14. My friends brag about their sexual exploits.
- _____ 15. My friends suggest dates to each other who are known to be sexually easy.
- _____ 16. My parents encourage me to have sex with many people before I get married.
- _____ 17. Among my friends, people seldom discuss their sexuality.
- _____ 18. Among my friends, women who have the most sexual experience are the most highly regarded.
- _____ 19. My father would have felt okay about my having casual sexual encounters.
- _____ 20. My mother would only have approved of me having sex in a serious relationship.

Appendix I

Sexuality Education Program Feature/Program Outcome Inventory

Sexuality Education Program Outcome Inventory

This survey is designed to gather important information about your feelings concerning human sexuality education you may have had in high school.

- A. Have you taken a course focused on human sexuality in high school? Yes No
- B. Have you taken a course focused on human sexuality in junior high or middle school? Yes No
- C. If you **did not** have a specific course focused on human sexuality in junior high, middle, or high school, please indicate which classes (including grade level) you received the most “sex ed” in school here:

Below is a list of statements about the sexual education you had in high school. Please respond to each statement by writing one response based on the following scale:

SA –Strongly Agree; A—Agree; D—Disagree; SD—Strongly disagree; DK—Don’t know

- _____ 1. The teacher was enthusiastic about teaching the course.
- _____ 2. The teacher discussed topics in a way that made me feel comfortable.
- _____ 3. The teacher encouraged me to talk about my opinions.
- _____ 4. The teacher encouraged me to think about my own values concerning sexuality.
- _____ 5. The teacher encouraged me to consider the use of birth control in order to avoid an unplanned pregnancy.
- _____ 6. I was encouraged to ask questions about sexuality in class.
- _____ 7. The teacher provided class activities aimed at improving decision-making skills.
- _____ 8. I was permitted to express my own values in the class.
- _____ 9. The teacher provided class activities aimed at improving factual knowledge.
- _____ 10. The teacher was comfortable during class discussions concerning sexuality.
- _____ 11. The teacher got along well with students in class.
- _____ 12. The teacher encouraged me to think about the consequences of sexual relationships before I enter into them.

The following is a list of statements which relate to your high school experiences of sexual education. Please write the response that best represents your feelings about each statement.

As a result of your high school sexual education, do you feel you have a *greater understanding of*:

SA –Strongly Agree; A—Agree; D—Disagree; SD—Strongly disagree; DK—Don’t know

- _____ 13. Physical changes during adolescence.
- _____ 14. Human reproduction.
- _____ 15. The emotional needs of adolescents.
- _____ 16. The social needs of adolescents.
- _____ 17. The emotional changes during adolescence.
- _____ 18. The social changes during adolescence.
- _____ 19. Abstinence as an alternative to sexual intercourse.
- _____ 20. The effectiveness of different birth control methods.
- _____ 21. The probability of becoming pregnant.
- _____ 22. The problems associated with adolescent parenthood.
- _____ 23. Sexually transmitted infections.
- _____ 24. Common myths concerning sexuality.
- _____ 25. The positive role of sexuality in your life.
- _____ 26. Your long-range life goals.
- _____ 27. Your own emotional needs.
- _____ 28. Your sexual feelings.
- _____ 29. Being responsible for your own feelings.
- _____ 30. Accepting your own body variation.
- _____ 31. Accepting your own set of rules to guide your behavior.

As a result of your high school sexual education, do you feel you have a *greater ability to*:

SA –Strongly Agree; A—Agree; D—Disagree; SD—Strongly disagree; DK—Don’t know

- _____ 32. Make decisions.
- _____ 33. Communicate your feelings verbally.
- _____ 34. Discuss sexual behavior with your potential partner.
- _____ 35. Express your desire to use birth control in order to avoid an unplanned pregnancy.
- _____ 36. Express your desire not to be involved sexually if you don’t wish to be.
- _____ 37. Resolve conflicts that may exist between you and another person.
- _____ 38. Respect the individual dignity of each person.
- _____ 39. Feel comfortable discussing sexual issues with friends.
- _____ 40. Feel comfortable with your own bodily functions.
- _____ 41. Be satisfied with who you are.
- _____ 42. Form your own sex role standards.
- _____ 43. Be responsible for your own behavior.
- _____ 44. Accept your own body variations.
- _____ 45. Accept your own set of rules

The following is a scale representing how topics were presented in your high school sexual education.

- 0—Not at all: the topic was not discussed.
- 1—Informally covered: the topic was discussed only if a student asked a question about it.
- 2—Formally covered: the topic was discussed in a class period or unit in which the teacher presented information through lecture, discussion, class activity, media, or guest speaker.
- DK—Don't know: you do not have enough information to respond to the statement.

Please write the response that best represents how you feel each topic was covered in your high school sexual education.

- _____ 46. Anatomy and physiology
- _____ 47. Biological aspects of human reproduction
- _____ 48. The probability of becoming pregnant
- _____ 49. Human sexuality as an aspect of one's total personality
- _____ 50. The relationship between how one feels about one's self and one's behavior
- _____ 51. The emotional needs during adolescence
- _____ 52. The social needs during adolescence
- _____ 53. Adolescent pregnancy
- _____ 54. Students' attitudes about sexual activity
- _____ 55. Students' feelings about sexual activity
- _____ 56. The range of sexual behaviors
- _____ 57. Sexually transmitted infections
- _____ 58. Common myths concerning sexuality
- _____ 59. Students' attitudes about sex roles
- _____ 60. Students' feelings about sex roles
- _____ 61. Peer pressure and sexual behavior
- _____ 62. Avoiding unwanted sexual experiences
- _____ 63. Advantages of the various contraceptive methods
- _____ 64. Disadvantages of the various contraceptive methods
- _____ 65. The effectiveness of the various contraceptive methods
- _____ 66. Improving decision-making skills
- _____ 67. Improving problem-solving skills
- _____ 68. Improving communication skills with peers
- _____ 69. Improving communication skills with parents.

Appendix J
Mathtech Questionnaires

We are trying to find out if this program is successful. You can help us by completing this questionnaire.

To keep your answers confidential and private, do *not* put your name anywhere on this questionnaire. Please use a regular pen or pencil so that all questionnaires will look about the same and no one will know which is yours.

Because this study is important, your answers are also important. Please answer each question carefully.

Knowledge Test

Please circle the one best answer to each of the questions below.

1. By the time teenagers graduate from high schools in the United States:
 - a. only a few have had sex (sexual intercourse).
 - b. about half have had sex.
 - c. about 80% have had sex.

2. It is harmful for a woman to have sex (sexual intercourse) when she:
 - a. is pregnant.
 - b. is menstruating.
 - c. has a cold.
 - d. has a sexual partner with syphilis.
 - e. none of the above.

3. Some contraceptives:
 - a. can be obtained only with a doctor's prescription.
 - b. are available at family planning clinics.
 - c. can be bought over the counter at drug stores.
 - d. can be obtained by people under 18 without their parents' permission.
 - e. all of the above.

4. If 10 heterosexual couples have sexual intercourse regularly without using any kind of birth control, the number of couples who become pregnant by the end of 1 year is about:
 - a. one.
 - b. three.
 - c. six.
 - d. nine.
 - e. none of the above.

5. When unmarried young women learn they are pregnant, the largest group of them decide:
 - a. to have an abortion.
 - b. to put the child up for adoption.
 - c. to raise the child at home.
 - d. to marry and raise the child with the husband.
 - e. none of the above

6. People having sexual intercourse can best prevent getting a sexually transmitted infection (STI) by using:
 - a. condoms (rubbers).
 - b. contraceptive foam.
 - c. the pill.
 - d. withdrawal (pulling out).

7. If a heterosexual couple has sexual intercourse and uses no birth control, the woman might get pregnant:
 - a. anytime during the month.
 - b. only 1 week before menstruation begins.
 - c. only during menstruation.
 - d. only 1 week after menstruation begins.
 - e. only 2 weeks after menstruation begins.

8. The method of birth control that is *least* effective is:
 - a. a condom with foam.
 - b. the diaphragm with spermicidal jelly.
 - c. withdrawal (pulling out).
 - d. the pill.
 - e. abstinence (not having intercourse).

9. It is possible for a woman to become pregnant:
 - a. the first time she has sex (sexual intercourse).
 - b. if she has sexual intercourse during her menstrual period.
 - c. if she has sexual intercourse standing up.
 - d. if sperm get near the opening of the vagina, even though the man's penis does not enter her body.
 - e. all of the above.

10. It is impossible now to cure:
 - a. syphilis.
 - b. gonorrhea.
 - c. herpes virus #2.
 - d. vaginitis.
 - e. all of the above.

11. When men and women are physically mature:
 - a. each female ovary releases two eggs each month.
 - b. each female ovary releases millions of eggs each month.
 - c. male testes produce one sperm for each ejaculation (climax).
 - d. male testes produce millions of sperm for each ejaculation (climax).
 - e. none of the above.
12. Individuals who choose to have sexual intercourse may possibly:
 - a. have to deal with a pregnancy.
 - b. feel guilty.
 - c. become more close to their sexual partners.
 - d. become less close to their sexual partners.
 - e. all of the above.
13. To use a condom the correct way, a person must:
 - a. leave some space at the tip for the guy's fluid.
 - b. use a new one every time sexual intercourse occurs.
 - c. hold it on the penis while pulling out of the vagina.
 - d. all of the above.
14. The proportion of American girls who become pregnant before turning 20 is:
 - a. 1 out of 3.
 - b. 1 out of 11.
 - c. 1 out of 43.
 - d. 1 out of 90.
15. Treatment for sexually transmitted infections (STIs) is best if:
 - a. both partners are treated at the same time.
 - b. only the partner with symptoms sees a doctor.
 - c. the person takes the medicine only until the symptoms disappear.
 - d. the partners continue having sex (sexual intercourse).
 - e. all of the above.
16. Syphilis:
 - a. is one of the most dangerous STIs.
 - b. is known to cause blindness, insanity, and death if untreated.
 - c. is first detected as a chancre sore on the genitals.
 - d. all of the above.
17. If people have sexual intercourse, the advantage of using condoms is that they:
 - a. help prevent getting or giving STIs.
 - b. can be bought in drug stores by either sex.
 - c. do not have dangerous side effects.
 - d. do not require a prescription.
 - e. all of the above.

18. If two people want to have a close relationship, it is important that they:
- trust each other and are honest with each other.
 - date other people
 - always think of the other person first.
 - always think of their own needs first.
 - all of the above.
19. The rhythm method (natural family planning):
- means couples *cannot* have intercourse during certain days of the woman's menstrual cycle.
 - requires the woman to keep a record of when she has her period.
 - is effective less than 80% of the time.
 - is recommended by the Catholic church.
 - all of the above.
20. The pill
- can be used by any woman.
 - is a good birth control method for women who smoke.
 - usually makes menstrual cramping worse.
 - must be taken for 21 or 28 days in order to be effective.
 - all of the above.
21. Gonorrhea:
- is 10 times more common than syphilis.
 - is a disease that can be passed from mothers to their children during birth.
 - makes men and women sterile (unable to have babies).
 - is often difficult to detect in women.
 - all of the above.
22. People choosing a birth control method:
- should think only about the cost of the method.
 - should choose whatever method their friends are using.
 - should learn about all the methods before choosing the one that's best for them.
 - all of the above.

Attitude and Value Inventory

The questions below are not a test of how much you know. We are interested in what you believe about some important issues. Please rate each statement according to how much you agree or disagree with it. Everyone will have different answers. Your answer is correct if it describes you very well.

- Circle: 1 = if you Strongly Disagree with the statement
 2 = if you Somewhat Disagree with the statement
 3 = if you feel Neutral about the statement.
 4 = if you Somewhat Agree with the statement.
 5 = if you Strongly Agree with the statement.

1 2 3 4 5	1. I am very happy with my friendships.
1 2 3 4 5	2. Unmarried people should not have sex (sexual intercourse)
1 2 3 4 5	3. Overall, I am satisfied with myself.
1 2 3 4 5	4. Two heterosexual people having sex should use some form of birth control if they aren't ready for a child.
1 2 3 4 5	5. I'm confused about my personal sexual values and beliefs.
1 2 3 4 5	6. I often find myself acting in ways I don't understand.
1 2 3 4 5	7. I am not happy with my sex life.
1 2 3 4 5	8. Men should not hold jobs traditionally held by women.
1 2 3 4 5	9. People should never take "no" for an answer when they want to have sex.
1 2 3 4 5	10. I don't know what I want out of life.
1 2 3 4 5	11. Families do very little for their children.
1 2 3 4 5	12. Sexual relationships create more problems than they're worth.
1 2 3 4 5	13. I'm confused about what I should and should not do sexually.
1 2 3 4 5	14. I know what I want and need emotionally.
1 2 3 4 5	15. No one should pressure another person into sexual activity.
1 2 3 4 5	16. Birth control is not very important.
1 2 3 4 5	17. I know what I need to be happy.
1 2 3 4 5	18. I am not satisfied with my sexual behavior (sex life).
1 2 3 4 5	19. I usually understand the way I act.
1 2 3 4 5	20. People should not have sex before marriage.
1 2 3 4 5	21. I do not know much about my own physical and emotional sexual responses.
1 2 3 4 5	22. It is all right for two people to have sex before marriage if they are in love.
1 2 3 4 5	23. I have a good idea of where I'm headed in the future.
1 2 3 4 5	24. Family relationships are not important.
1 2 3 4 5	25. I have trouble knowing what my beliefs and values are about my personal sexual behavior.

- Circle: 1 = if you Strongly Disagree with the statement
 2 = if you Somewhat Disagree with the statement
 3 = if you feel Neutral about the statement.
 4 = if you Somewhat Agree with the statement.
 5 = if you Strongly Agree with the statement.

1 2 3 4 5	26. I feel I do not have much to be proud of.
1 2 3 4 5	27. I understand how I behave around others.
1 2 3 4 5	28. Women should behave differently from men most of the time.
1 2 3 4 5	29. People should have sex only if they are married.
1 2 3 4 5	30. I know what I want out of life.
1 2 3 4 5	31. I have a good understanding of my own personal feelings and reactions.
1 2 3 4 5	32. I don't have enough friends.
1 2 3 4 5	33. I'm happy with my sexual behavior now.
1 2 3 4 5	34. I don't understand why I behave with my friends as I do.
1 2 3 4 5	35. At times I think I'm no good at all.
1 2 3 4 5	36. I know how I react in different sexual situations.
1 2 3 4 5	37. I have a clear picture of what I'd like to be doing in the future.
1 2 3 4 5	38. My friendships are not as good as I would like them to be.
1 2 3 4 5	39. Sexually, I feel like a failure.
1 2 3 4 5	40. More people should be aware of the importance of birth control.
1 2 3 4 5	41. At work and at home, women should not have to behave differently from men, when they are equally capable.
1 2 3 4 5	42. Sexual relationships make life too difficult.
1 2 3 4 5	43. I wish my friendships were better.
1 2 3 4 5	44. I feel that I have many good personal qualities.
1 2 3 4 5	45. I am confused about my reactions in sexual situations.
1 2 3 4 5	46. It is all right to pressure someone into sexual activity.
1 2 3 4 5	47. People should not pressure others to have sex with them.
1 2 3 4 5	48. Most of the time my emotional feelings are clear to me.
1 2 3 4 5	49. I have my own set of rules to guide my sexual behavior (sex life).
1 2 3 4 5	50. Women and men should be able to have the same jobs, when they are equally capable.
1 2 3 4 5	51. I don't know what my long-range goals are.
1 2 3 4 5	52. When I'm in a sexual situation, I get confused about my feelings.
1 2 3 4 5	53. Families are very important.
1 2 3 4 5	54. It is all right to demand sex from a girlfriend or boyfriend.
1 2 3 4 5	55. A sexual relationship is one of the best things a person can have.
1 2 3 4 5	56. Most of the time I have a clear understanding of my feelings and emotions.
1 2 3 4 5	57. I am very satisfied with my sexual activities just the way they are.
1 2 3 4 5	58. Sexual relationships only bring trouble to people.

- Circle: 1 = if you Strongly Disagree with the statement
 2 = if you Somewhat Disagree with the statement
 3 = if you feel Neutral about the statement.
 4 = if you Somewhat Agree with the statement.
 5 = if you Strongly Agree with the statement.

1 2 3 4 5	59. Birth control is not as important as some people say.
1 2 3 4 5	60. Family relationships cause more trouble than they're worth.
1 2 3 4 5	61. If two heterosexual people have sex and aren't ready to have a child, it is very important they use birth control.
1 2 3 4 5	62. I'm confused about what I need emotionally.
1 2 3 4 5	63. It is all right for two people to have sex before marriage.
1 2 3 4 5	64. Sexual relationships provide an important and fulfilling part of life.
1 2 3 4 5	65. People should be expected to behave in certain ways just because they are male or female.
1 2 3 4 5	66. Most of the time I know why I behave the way I do.
1 2 3 4 5	67. I feel good having as many friends as I have.
1 2 3 4 5	68. I wish I had more respect for myself.
1 2 3 4 5	69. Family relationships can be very valuable.
1 2 3 4 5	70. I know for sure what is right and wrong sexually for me.

Behavior Inventory

The questions below ask how often you have done some things. Some of the questions are personal and ask about your social life and sex life. Some questions will not apply to you. Please do not conclude from the questions that you should have had all of the experiences the questions ask about. Instead, just mark whatever answer describes you best.

- Circle: 1 = if you do it *almost never*, which means about 5% of the time or less.
 2 = if you do it *sometimes*, which means about 25% of the time.
 3 = if you do it *half the time*, which means about 50% of the time.
 4 = if you do it *usually*, which means about 75% of the time.
 5 = if you do it *almost always*, which means about 95% of the time.
 NA = if the question *does not apply* to you.

1 2 3 4 5 NA	1. When things you've done turn out poorly, how often do you take responsibility for your behavior and its consequences?
1 2 3 4 5 NA	2. When things you've done turn out poorly, how often do you blame others?
1 2 3 4 5 NA	3. When you are faced with a decision, how often do you take responsibility for making a decision about it?

- Circle: 1 = if you do it *almost never*, which means about 5% of the time or less.
 2 = if you do it *sometimes*, which means about 25% of the time.
 3 = if you do it *half the time*, which means about 50% of the time.
 4 = if you do it *usually*, which means about 75% of the time.
 5 = if you do it *almost always*, which means about 95% of the time.
 NA = if the question *does not apply* to you.

1 2 3 4 5 NA	4. When you have to make a decision, how often do you think hard about the consequences of each possible choice?
1 2 3 4 5 NA	5. When you have to make a decision, how often do you get as much information as you can before making the decision?
1 2 3 4 5 NA	6. When you have to make a decision, how often do you first discuss it with others?
1 2 3 4 5 NA	7. When you have to make a decision about your sexual behavior (for example, going out on a date, holding hands, kissing, petting, or having sex), how often do you take responsibility for the consequences?
1 2 3 4 5 NA	8. When you have to make a decision about your sexual behavior, how often do you think hard about the consequences of each possible choice?
1 2 3 4 5 NA	9. When you have to make a decision about your sexual behavior, how often do you first get as much information as you can?
1 2 3 4 5 NA	10. When you have to make a decision about your sexual behavior, how often do you first discuss it with others?
1 2 3 4 5 NA	11. When you have to make a decision about your sexual behavior, how often do you make it on the spot without worrying about the consequences?
1 2 3 4 5 NA	12. When a friend wants to talk with you, how often are you able to clear your mind and really listen to what your friend has to say?
1 2 3 4 5 NA	13. When a friend is talking with you, how often do you ask questions if you don't understand what your friend is saying?
1 2 3 4 5 NA	14. When a friend is talking with you, how often do you nod your head and say "yes" or something else to show that you are interested?
1 2 3 4 5 NA	15. When you want to talk with a friend, how often are you able to get your friend to really listen to you?
1 2 3 4 5 NA	16. When you talk with a friend, how often do you ask for your friend's reaction to what you've said?
1 2 3 4 5 NA	17. When you talk with a friend, how often do you let your feelings show?
1 2 3 4 5 NA	18. When you are with a friend you care about, how often do you let that friend know you care?

- Circle: 1 = if you do it *almost never*, which means about 5% of the time or less.
 2 = if you do it *sometimes*, which means about 25% of the time.
 3 = if you do it *half the time*, which means about 50% of the time.
 4 = if you do it *usually*, which means about 75% of the time.
 5 = if you do it *almost always*, which means about 95% of the time.
 NA = if the question *does not apply* to you.

1 2 3 4 5 NA	19. When you talk with a friend, how often do you include statements like “my feelings are...,” “the way I think is...,” or “it seems to me”?
1 2 3 4 5 NA	20. When you are alone with a date or partner, how often can you tell him/her your feelings about what you want to do and do not want to do sexually?
1 2 3 4 5 NA	21. If a person puts pressure on you to be involved sexually and you don’t want to be involved, how often do you say “no”?
1 2 3 4 5 NA	22. If a person puts pressure on you to be involved sexually and you don’t want to be involved, how often do you succeed in stopping it?
1 2 3 4 5 NA	23. If you have sexual intercourse with your partner, how often can you talk with him/her about birth control?
1 2 3 4 5 NA	24. If you have sexual intercourse and want to use birth control, how often do you insist on using birth control?
1 2 3 4 5 NA	25. If you have sexual intercourse with your partner, how often can you talk with him/her about STI protection?
1 2 3 4 5 NA	26. If you have sexual intercourse and want to use STI protection, how often do you insist on using STI protective devices?

In this section, we want to know how uncomfortable you are doing different things. Being “uncomfortable” means that it is difficult for your and it makes you nervous and uptight. For each item, circle the number that describes you best, but if the item doesn’t apply to you, circle NA.

- Circle: 1 = if you are *comfortable*.
 2 = if you are *a little uncomfortable*.
 3 = if you are *somewhat uncomfortable*.
 4 = if you are *very uncomfortable*.
 NA = if the question *does not apply* to you.

1 2 3 4 NA	27. Getting together with a group of friends of the sex you are attracted to.
1 2 3 4 NA	28. Going to a party.
1 2 3 4 NA	29. Talking with young adults of the sex you are attracted to.
1 2 3 4 NA	30. Going out on a date.
1 2 3 4 NA	31. Talking with friends about sex.

54. Last month, how many times did you have sex (sexual intercourse)?	_____ times in the last month
55. Last month, how many times did you have sex when you or your partner did not use any form of birth control?	_____ times in the last month NA (not in a heterosexual relationship)
56. Last month, how many times did you have sex when you or your partner used a diaphragm, withdrawal (pulling out before releasing fluid), rhythm (not having sex on fertile days), or foam without condoms?	_____ times in the last month NA (not in a heterosexual relationship)
57. Last month, how many times did you have sex when you or your partner used the pill, another form of hormonal birth control (the shot, the patch, the ring, etc.), condoms, or an IUD?	_____ times in the last month NA (not in a heterosexual relationship)
58. Last month, how many times did you have sex when you or your partner did not use any form of STI protection?	_____ times in the last month
59. Last month, how many times did you have sex when you or your partner used condoms or dental dams?	_____ times in the last month
60. During the last month, how many times have you had a conversation or discussion about sex with your parents?	_____ times in the last month
61. During the last month, how many times have you had a conversation or discussion about sex with your friends?	_____ times in the last month
62. During the last month, how many times have you had a conversation or discussion about sex with a date or partner?	_____ times in the last month
63. During the last month, how many times have you had a conversation or discussion about birth control with your parents?	_____ times in the last month
64. During the last month, how many times have you had a conversation or discussion about birth control with your friends?	_____ times in the last month
65. During the last month, how many times have you had a conversation or discussion about birth control with a date or partner?	_____ times in the last month
66. During the last month, how many times have you had a conversation or discussion about STI protection with your parents?	_____ times in the last month
67. During the last month, how many times have you had a conversation or discussion about STI protection with your friends?	_____ times in the last month

68. During the last month, how many times have you had
a conversation or discussion about STI protection with
a date or partner? _____ times in the last month

Thank you for completing this questionnaire!

Appendix K

Full ANOVA Results for Scales with Significant Change

Table K1

Full ANOVA Results for Scales with Significant Change

Scale	<i>F</i>	<i>df</i>	<i>p</i>	η^2
<i>AVI Understanding of personal sexual response</i>				
Interaction: Time*Group	10.196	1, 51	0.002	0.167
Main Effect: Time	17.386	1	0.000	0.254
Main Effect: Group	0.217	1	0.643	0.004
<i>AVI Attitude toward sexuality in life</i>				
Interaction: Time*Group	8.262	1, 50	0.006	0.142
Main Effect: Time	3.296	1	0.075	0.062
Main Effect: Group	1.690	1	0.200	0.033
<i>AVI Satisfaction with personal sexuality</i>				
Interaction: Time*Group	4.708	1, 51	0.035	0.085
Main Effect: Time	1.768	1	0.190	0.034
Main Effect: Group	1.190	1	0.281	0.023
<i>AVI Attitude toward gender roles</i>				
Interaction: Time*Group	4.102	1, 54	0.048	0.071
Main Effect: Time	0.858	1	0.358	0.016
Main Effect: Group	0.003	1	0.954	0.000
<i>AVI Recognition of the importance of the family</i>				
Interaction: Time*Group	4.057	1, 52	0.049	0.072
Main Effect: Time	0.095	1	0.759	0.002
Main Effect: Group	3.231	1	0.078	0.995
<i>BI Birth control assertiveness skills</i>				
Interaction: Time*Group	4.543	1, 28	0.042	0.140
Main Effect: Time	0.441	1	0.512	0.015
Main Effect: Group	0.003	1	0.958	0.000

Note. Scales in italics identified for poor reliability.

CURRICULUM VITAE

BRENNA M. WERNERSBACH

1623 Katherine Kiker Road
Charlotte, NC 28213

763) 234-2069
Brenna.Wernersbach@unc.edu

EDUCATION

- Ph.D. Utah State University, Logan, Utah
2013 Combined Clinical/Counseling/School Psychology (APA accredited)
Dissertation: *Healthy Sexuality: Evaluating a Psychoeducation Group Promoting Knowledge, Communication, and Positive Experiences.*
Chair: Renee V. Galliher, Ph.D.
- M.S. Utah State University, Logan, Utah
2011 Counseling Psychology
Thesis: *The Impact of Study Skills Courses on Academic Self-Efficacy in College Students.*
Chair: Susan L. Crowley, Ph.D.
- B.A.S. University of Minnesota, Duluth
2007 Major: Psychology, Minor: Business

CLINICAL WORK EXPERIENCE

- 9/13 – 9/15 **Postdoctoral Psychology Fellow**
Program in Human Sexuality, University of Minnesota
Responsibilities to include: Assessment and treatment of a variety of sexual problems in childhood and adulthood, through individual and group modalities, including sexual and relationship dysfunction, conflict or confusion regarding sexual orientation, gender dysphoria, child and adolescent sexual problems, compulsive sexual behaviors, sexual offenses, and sexual abuse.
Supervisor: Eli Coleman, Ph.D.
- 8/12 – 8/13 **Predoctoral Psychology Intern**
UNC Charlotte Counseling Center, Charlotte, NC
Responsibilities: Conduct intake evaluations and crisis consultations; provide individual and couples counseling; facilitate counseling groups, including Women Survivors of Sexual Trauma and LGBTQA Discussion

and Support group; develop liaison relationship with multicultural resource center with emphasis on LGBTQA community on campus; provide community education regarding mental health and diversity issues through outreach programming.

Supervisors: Terri Rhodes, Ph.D., Erica Lennon, Psy.D., Gene Edwards, Ph.D.

Total hours (in progress): 1325 Direct contact hours (in progress): 380

08/10 –
5/11

Graduate Assistant Therapist

USU Counseling and Psychological Services, Logan, UT

Responsibilities: Conducted intake evaluations and crisis consults, developed treatment plans, wrote reports, provided individual therapy, co- led groups including stress and anxiety management, DBT skills training, and Women’s Identity, directly supervised an undergraduate peer educator, provided on-campus outreach presentations, participated in weekly group and individual supervision, and participated in weekly staff meetings and case conferences.

Supervisors: LuAnn Helms, Ph.D., David Bush, Ph.D.

Total hours: 653.5 Direct contact hours: 272.5

CLINICAL PRACTICA EXPERIENCE

08/10 –
5/11

Student Therapist – Practicum in Child Clinical/School Psychology

Avalon Hills Residential Eating Disorder Treatment Facility: Adolescent Unit, Petersboro, UT

Responsibilities: Co-led experiential groups including body image, recovery maintenance, ACT, DBT skills, and process group; conducted psychological and learning disorder assessment including report writing; participated in treatment team collaboration and consultation.

Supervisor: Tera Lensegrav-Benson, Ph.D.

Total hours: 296.25 *Direct contact hours:* 121.5

8/09 – 5/10

Student Therapist – Practicum in Clinical/Counseling Psychology

USU Counseling and Psychological Services, Logan, UT

Responsibilities: Conducted intake evaluations, developed treatment plans, provided individual therapy, wrote reports, prepared and delivered outreach presentations including anxiety and depression screenings and body image awareness, co-led Women’s Identity Group.

Supervisors: Eri Bentley, Ph.D., Chris Chapman, M.S.

Total hours: 320, *Direct contact hours:* 98.5

8/08 – 5/09

Student Therapist – Practicum in Integrated Child/Adult Counseling

USU Psychology Department Community Clinic, Logan, Utah

Responsibilities: Conducted intake evaluations, conducted psychological

evaluations, developed treatment plans, wrote reports, consulted with other professionals including school consultation, and provided individual therapy to children, adolescents, and families.

Supervisors: Susan Crowley, Ph.D., Melanie Domenech-Rodriguez, Ph.D.

Total hours: 444.5, *Direct contact hours:* 113.5

- 5/08 – 8/08 **Student Therapist – Practicum in Psychology**
 USU Psychology Department Community Clinic, Logan, Utah
Responsibilities: Conducted intake evaluations, conducted psychological evaluations, developed treatment plans, wrote reports, and provided individual therapy to children, adolescents, and families including co-therapy.
Supervisors: Susan Crowley, Ph.D., Gretchen Gimpel Peacock, Ph.D.
Total hours: 104, *Direct contact hours:* 17.5
- 1/08 – 5/08 **Student Therapist – Introductory Practicum**
 USU Psychology Department Community Clinic, Logan, Utah
Responsibilities: Conducted intake evaluations, developed treatment plans, consulted with other professionals including school consultation, and provided individual therapy to children, adolescents, and families via co-therapy with an advanced doctoral student.
Supervisors: Melanie Domenech-Rodriguez, Ph.D.
Total hours: 168, *Direct contact hours:* 28

CLINICALLY RELATED VOLUNTEER EXPERIENCES

- 10/11 – 3/12 **Healthy Sexuality Group Facilitator**
 Doctoral dissertation project: Wrote leader manual, facilitated experiential leader training, and co-led four session psychoeducational group promoting accurate knowledge, partner communication, and positive sexual experiences. Groups consist of 8-10 participants for a total sample size of 57.
Supervisor: Renee V. Galliher, Ph.D. *Direct contact hours:* 36
- 9/11 – 5/12 **LGBTQA Support Group Co-Facilitator**
 USU Counseling and Psychological Services and Access & Diversity Center
Responsibilities include: Co-lead weekly drop-in brown bag support group with CAPS staff member. Topics of discussion include coming out, dating and relationships, healthy community, dealing with discrimination, and others based on themes emerging among attendees.
- 5/11 – 7/12 **USU Allies on Campus Steering Committee Member**
Responsibilities include: Attend steering committee meetings; revised training materials including seminar presentation and manual; deliver

training seminars to USU students, faculty, and staff; provide support to LGBTQA members of the campus community through consultation and referral; coordinate activities for national coming out day and other public awareness events; provide consultation to Love Is For Everyone (L.I.F.E.) Gay-Straight Alliance leadership council.

- 6/09 – 6/11 **Crisis Response Advocate**
Community Abuse Prevention Services Agency (CAPSA), Logan, Utah
Responsibilities included: Responded to crisis calls to meet clients at shelter, hospital, or police station; collected information for case manager; assisted with safety planning and risk assessment; checked clients into shelter. Additional support to agency included staffing the office, cleaning the shelter, manning booths at local community events, and assisting in training new volunteers.
Supervisor: Ruth Wilson, volunteer coordinator
- 5/06 – 8/06 **Undergraduate Internship in Applied Psychology**
Northwoods Children's Services, Duluth, Minnesota
Responsibilities included: Assisted staff in after school supervision of adolescents. Developed and facilitate weekly group activities, logged student progress, tutored and mentored students, participated in weekly staff meetings to discuss student progress, accompanied students on field trips and provided supervision at community based events.
Supervisor: Sandra Woolum, Ph.D.

Selected Outreach Presentations Conducted

- 1/13 – 4/13 **SafeZone 2.0 Discussion Workshops**
Co-facilitated a series of advanced topic discussions for faculty and staff. Topics included history of community language, advanced trans* issues, active ally engagement, and queer professional identities post-college.
- 11/12 **Friendly Peer Training**
Presented a one-hour workshop on LGBTQA terminology, discrimination, ally-behaviors, and campus resources.
- 10/12, 3/13 **Discussing Sex and Sexuality as a Peer Educator**
Invited as a guest presenter for campus peer educator training. Topics included assessing knowledge, attitudes, and values; facilitating communication; and identifying reliable resources.
- 8/12 **Campus Connect Suicide Prevention Training**
Presented a three-hour workshop to Resident Advisors in training on suicide risk assessment and intervention, including campus resources.

- 5/12 **Facilitating Healthy Sexuality in Clinical Work**
Presented a two-hour seminar to counseling center staff and trainees. Topics included sexual psychoeducation, sexual social skills, sexual pain disorders, etc.
- 4/12 **LGBTQ Clients and Community: Clinical Considerations**
Presented an introduction to clinical work with LGBT clients at USU Combined Psychology Program graduate student monthly meeting.
- 2/12 **Student Leadership Models**
Invited as a panelist for discussion of leadership characteristics and strategies hosted by USU S.A.F.E. (Students and Allies For Education) student group.
- 5/11, 9/11 **Cultural Competency and the LGBTQ Community**
Presented a 90-minute cultural competency training to crisis advocates in-training at local domestic violence and sexual assault shelter.
- 2/11 – 4/11 **Healthy Sexuality Workshop**
Presented a two-part 90-minute workshop on understanding sexual experiences, values, desires, and boundaries with an emphasis on fostering self-efficacy and communication skills. (Four sessions total)
- 1/11 **Healthy Relationships and Communication**
Provided consultation to Love Is For Everyone (L.I.F.E.) Gay-Straight Alliance on campus regarding fostering healthy relationships within the community.
- 10/10, 2/11, 3/11 **Body Image Workshop**
Presented 90-minute workshops on improving body image and understanding media influence on body image through USU Counseling and Psychological Services.
- 3/10, 2/11 **Body Image Fair**
Developed informal poster on “Media Influence on Body Image,” designed interactive activities, consulted with undergraduate volunteers promoting event through USU Counseling and Psychological Services.
- 2/10 **Women’s Issues in Counseling**
Invited as a panelist for discussion of concerns and considerations specific to working with female counseling clients in a graduate level diversity course through USU Department of Psychology.
- 9/09 **Sexual Abuse Awareness**
Available to meet with students to debrief after a guest presentation on psychological consequences of date rape. Sponsored by USU Counseling and Psychological Services and USU Sexual Assault and Anti-Violence Information (SAAVI).

FURTHER WORK EXPERIENCE

- 8/11 – 5/12 **Graduate Assistant Learning Specialist**
 USU Academic Resource Center, Logan, UT
Responsibilities: Work one-on-one with students to develop study skills and promote academic success including areas such as goal-setting, motivation, time management, note-taking, textbook reading, and managing stress and test anxiety, develop workshops addressing similar topics for group-level interventions, provided on-campus outreach and information presentations, and participated in weekly staff meetings.
Supervisor: Deborah Jensen, M.S.

TEACHING EXPERIENCE

- 8/11 – 5/12 **Independent Instructor**
 PSY 1730: Strategies for Academic Success
 USU Academic Resource Center, Logan, UT
 Delivered on campus lectures, developed course materials, graded exams and assignments, and available for individual student consultation.
Supervisor: Deborah Jensen, M.S.
- 1/10 – 5/10 **Independent Instructor**
 PSY 5100: Effective Social Skills Interventions
 USU Department of Psychology, Logan, UT
 Delivered on campus lectures, developed course materials, graded exams and projects, and held office hours for undergraduate students.
- 8/09 – 5/10 **Teaching Assistant**
 PSY 1010: General Psychology
 USU Department of Psychology, Logan, UT
 Administered three weekly one-hour discussion-based labs for 100 undergraduate students, selected and prepared reading, video, and writing assignments for students, graded student assignments, administered exams and entered exam grades, provided individualized help to students.
Supervisors: Angie Dahl, Ed.S., Jenna Glover, Ph.D.
- 8/07 – 5/09 **Teaching Assistant**
 PSY 3660: Educational Psychology for Teachers
 USU Department of Psychology, Logan, UT
 Devised lab curriculum and developed lab manual to complement lecture course, administered four weekly one-hour discussion and activity based labs for 100 students, provided individualized help to students, graded student case studies, administered exams.
Supervisor: Jennifer Hartman, M.S.

- 8/06 – 12/06 **Undergraduate Teaching Assistant**
 PSY 1010: General Psychology
UMD Department of Psychology, Duluth, MN
 Facilitated weekly group review sessions, provided individualized help to students, revised study tools such as practice exams, administered and graded exams and quizzes.
Supervisor: Lara LaCaille, Ph.D.
- 5/06 – 8/06 **Undergraduate Teaching Assistant**
 PSY 3215: Topics in Human Sexuality
UMD Department of Psychology, Duluth, MN
 Instructed and assisted students in accessing course materials online, communicated with students via email to answer questions and address concerns, helped develop new ideas for use of technology such as web-based discussion, assisted in grading assignments.
Supervisor: Paula Pedersen, Ph.D.

Guest Lectures within USU Department of Psychology

“Sex Drives, Sex Crimes, and Sexual Orientations”

Course: PSY 1010: General Psychology

Dates: 10/28/09, 2/16/10, 3/16/11, 10/17/11, 10/19/11

“Physical Changes and Body Image in Adolescence”

Course: PSY 2100: Adolescent Psychology

Date: 1/13/11

SELECTED TRAININGS & WORKSHOPS ATTENDED

- 4/13 *Intimacy in Group Psychotherapy: Connecting, Interpreting and Confronting.*
 Scott Rutan, Ph.D. Two day workshop. Carolina Group Psychotherapy Society. Duke University, Durham, NC.
- 11/11 *Third Annual TransAction Gender Conference.*
 Full day workshop. Utah Pride Center, Salt Lake City, UT.
- 4/11 *Addictive Behaviors*
 Jason R. Kilmer, Ph.D. Full day workshop. Counseling & Psychological Services, Utah State University, Logan, UT.
- 2/11 *Sexual Desire & Healing From an Extra-Marital Affair -Integrating Sexual Interventions into Couple Counseling*
 Barry McCarthy, Ph.D. Full day workshop. Utah Commission on Marriage, Salt Lake City, UT.

- 4/10 *An Integrated Approach to Complex Psychological Trauma*
John Briere, Ph.D. Full day workshop. USU Counseling & Psychological Services, Logan, UT.
- 9/09, 9/10 *LGBTQA Allies on Campus Training*
Maure Smith, GLBTA Coordinator. Half-day workshop. USU LGBTQA Services, Logan, UT.
- 6/09 **Legal and Ethical Aspects of Supervision**
Stephen Behnke, J.D., Ph.D. Full day workshop. Utah Psychological Association at Utah State University, Logan, UT
- 6/09 **Domestic Violence and Rape Survivor Advocate Training**
Ruth Wilson, Volunteer Coordinator. Forty-hour multiple session training. Community Abuse Prevention Services Agency, Logan, UT.
- 10/08 **Acceptance and Commitment Therapy Multicultural Training** Michael P. Twohig, Ph.D., & Melanie Domenech Rodríguez, Ph.D., Utah State University, Logan, UT.

AWARDS AND ELECTED POSITIONS

- 3/12 **Early Career and Lifetime Achievement Award: Student Spotlight**
Center for Women and Gender, Utah State University, Logan, UT
- 8/10 – 8/11 **Graduate Student Representative**
Department of Psychology, Utah State University, Logan, UT
Elected by peers to represent the students of the Combined Clinical/Counseling/School Psychology program. Attended faculty meetings and facilitated monthly student program meetings. Served as a liaison with faculty for student concerns. Helped coordinate and plan interviews with the admissions committee.
- 5/11 **LGBTQA Services and Allies on Campus Certificate of Appreciation**
Allies on Campus Program, Utah State University, Logan, UT
Recognition of dedication and important contributions to the Allies on Campus program and LGBTQA community on campus.
- 4/11 **Elwin C. Nielsen Scholarship**

PUBLICATIONS

- Wernersbach, B.M., Crowley, S., Bates, S., & Rosenthal, C. (Under review). Study skills courses impact on academic self-efficacy. *Journal of Developmental Education*.
- Crowell, K.A., Galliher, R.V., & Wernersbach, B.M. (In preparation). Sexual fluidity: Examining discordance between reported sexual identity and actual experiences of sexual behavior, attraction, and intimacy.

PROFESSIONAL PRESENTATIONS

Wernersbach, B.M., & Galliher, R.V. (April, 2012) *Sexuality education histories of emerging adults: Preferences, experiences, and satisfaction*. Poster presented at Allies on Campus LGBT Research Showcase, Utah State University, Logan, UT.

Wernersbach, B.M., & Galliher, R.V. (April, 2012) *Healthy Sexuality: Evaluating a psychoeducational group promoting knowledge, communication, and positive experiences*. Poster presented at Intermountain Graduate Symposium, Utah State University, Logan, UT.

Wernersbach, B.M., Crowley, S., & Rosenthal, C. (October, 2010). *The impact of study skills courses on academic self-efficacy in college students*. Poster presented at Utah University and Counseling Centers Conference, Park City, UT.

Wernersbach, B.M., & Woolum, S. (April, 2007). *Qualitative and quantitative factors which predict match length for children in mentoring relationships*. Poster presented at UMD Undergraduate Research/Artistic Showcase, Duluth, MN.

PROFESSIONAL AFFILIATIONS

American Psychological Association Graduate Student Affiliate
Society for the Psychological Study of Social Issues (Division 9)
Society for the Psychology of Women (Division 35)
Society for the Psychological Study of LGBT Issues (Division 44)
Psi Chi National Honor Society