RECOMMENDATIONS FOR SEX EDUCATION CURRICULUM COMPONENTS

A Project

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by

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Division of Social Work
Abstract
of
RECOMMENDATIONS FOR SEX EDUCATION CURRICULUM COMPONENTS
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Crystal Fickey
The purpose of this research study was to explore the relationship between adult demographics and recommendations for sex education curriculum components/modules. This quantitative exploratory survey research study investigated the sex education curriculum components/modules recommendations from 30 men and women. This study employed a non-probability convenience sampling method. There were significant chi-square associations found between gender and condom use; female birth control; types of romantic and sexual relationships; sexual self-esteem and well-being regarding sex; and LGBTQ topics. Participants who stated that sex education should be taught in school also provided recommendations on the components/modules they felt ought to be included in the curriculum. The findings from this study suggest that there is a need for sex education curriculum creators to address the sex education recommendations of adults from various demographic backgrounds. Implications for social work practice and policy are discussed.

__________________________, Committee Chair
Maria Dinis, Ph.D., M.S.W.

__________________________________
Date
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Chapter 1

STATEMENT OF THE PROBLEM

Sexually-transmitted infections (such as HIV and AIDS), teen pregnancies, and gender violence are independently chronic social and public health issues in our society today. The topic of HIV and AIDS alone has drawn global recognition and has exceeded expectations of researchers and scientists in its global impact (Piot, Bartos, Ghys, Walker, & Schwartlander, 2001). In regards to teen pregnancy rates, the United States consistently has the highest reported numbers within the developed nations (Stanger-Hall & Hall, 2011). Gender violence has been referred to as “the most pervasive yet least recognized human rights abuse in the world” (Obaid, 2010).

In an effort to combat or prevent such pervasive issues, programs have been created to serve some of the populations who are most affected by many of these issues: adolescents. In the United States, sex education programs were created with the goal to reduce, and hopefully eventually eradicate, these social issues that plague our youth. However, the topics in which sex education should include in its curriculum continue to be debated.

On one side of the debate, researchers, educators, teens, and a majority of parents want comprehensive sex education taught within schools (Constantine, Jerman, & Huang, 2007; Irvine, 2002; Jones, Herbert, & Mellor, 2011; Kirby, 2007). Research has consistently shown the ineffectiveness of abstinence-only models and rates of sexual infections, teen pregnancies, and reported teen dating violence reflect this unsuccessful approach.
On the other side of the debate, a small number of research studies, a minority number of parents, and a few policy makers have advocated for abstinence-only sex education models (Kirby, 2007; Landry, Darroch, Singh, & Higgins, 2003; Luker, 2006; Moran, 2000). Faith-based organizations have cited the few research studies that have supported findings related to abstinence-only models as evidence for continued federal level abstinence-only education. It should be noted that these research studies have also been widely criticized within the scientific community as being inaccurate and misleading (Bearman, & Bruckner, 2001; Kirby; Stranger-Hall & Hall, 2011).

These antithetical views on the topic have led to continued inconsistencies in the sex education programs that are currently being taught within the United States. Federal funding has supported abstinence-only education despite the overwhelming evidence of its ineffectiveness. States that chose to turn down federal funding in lieu of being able to teach comprehensive methods, vary in their curriculum components and models taught (Kraft et al., 2012; Landry, Darroch, Singh, & Higgins, 2003; McGarry, 2013). As information is becoming increasingly accessible through the Internet, it has become increasingly important to create a truly comprehensive and holistic sex education model for adolescents. In this regard, it is important to explore the opinions of adults who received sex education themselves to potentially aid in the creation of a more complete sex education program.

The research for this study will focus on sex education curriculum. In specific, it will explore the various types of curriculum components adults would include
in an ideal sex education curriculum and will provide analysis on how these desired components intersect with participant demographics.

In this chapter, the background of the issue of sex education will be discussed. The research problem of this study, the purpose of conducting the study, and the major research question being studied will also be addressed. In addition, a description and application of the theoretical framework to be used in furthering the understanding of educational components/modules recommended in a sex education curriculum will be examined. Definitions will be provided for the major terms used throughout the study. Lastly, assumptions, justifications and delimitations will be discussed, followed by a summary.

**Background of the Problem**

Educating individuals within communities about sex is a complex and charged issue within the United States. Its debate resides with scholars, public health officials, policy makers, parents, school districts, social workers, religious groups, and health care professionals. Current intervention methods of teaching abstinence-only have proven to be largely unsuccessful in both the United States and globally. Statistics collected on these issues is consistent in their findings related to various sexually-transmitted infections, teen pregnancy rates, and gender violence.

HIV and AIDS on their own have become the most critical pandemics facing the human race (Piot, Bartos, Ghys, Walker, & Schwartlander, 2001). Sexually-transmitted infections such as syphilis, gonorrhea, chlamydia, and trichomoniasis account for more than 448 million new global infections each year and are the main preventable cause of
infertility (World Health Organization [WHO], 2012). Within the United States, those same infections were the source of over 1.5 million new cases in 2010 (Centers for Disease Control [CDC], 2011).

One in four women will experience domestic violence in her lifetime, one in six women and one in thirty-three men will be victims of rape, one third of female homicide victims are killed by their intimate partners, and intimate partner violence accounts for more than 18.5 million mental health care visits each year (National Coalition Against Domestic Violence [NCADV], 2007). This does not include other gender violence such as those experienced within the lesbian, gay, bisexual, and transgender communities nor does it include child sexual abuse, stalking, teen marriages, forced pregnancy, sexual slavery, honor killings, and sex trafficking.

Collectively, the topic of sex is an enormous issue locally, nationally, and globally. In the United States, policy makers and public health officials began examining ways in which they could provide education and services to individuals affected by sexually-transmitted infections in the early twentieth century (Moran, 2003). Over time, the debate evolved into figuring out the role of government in sex education programs in schools and the curriculum components/modules best suited for our youth.

In today’s society, the debate over sex education consists of primarily two positions. There are those who believe there should be abstinence-only or no sex education taught in schools and then there are those who believe it is fundamental to teach comprehensive sex education in school. Those who have opinions about these views vary in their reasoning.
For proponents of abstinence-only or no sex education in schools, morality and religion are often cited as the rationale behind such a stance. Premarital sex is viewed as a sin and adolescents who are considering sexual relationships should abstain from the act altogether before committing themselves into marriage (Irvine, 2002; Luker, 2006). In conjunction to this viewpoint is the perceived belief that if adolescents are taught about sex while in school, it will entice them even further to act on what they have learned (Kirby, 2007). However, the reality is that abstinence-only education models are ineffective at keeping adolescents from engaging in sexual behavior for any period of time after having been exposed to abstinence-only education (Kirby, 2007; Satelli et al., 2006; Stanger-Hall & Hall, 2011). This means that adolescents are still engaging in sexual behaviors despite being taught otherwise. In addition, when those adolescents do become sexually active, they begin engaging in riskier behaviors such as the avoidance of using a condom during sex or using some form of contraceptive (Santelli et al, Stanger-Hall & Hall, 2011).

On the other side of the sex education argument are the views that comprehensive sex education is not only necessary to teach in schools but that it is also the responsibility of adults to prepare adolescents as much as possible for the inevitable. An overwhelming amount of research supports the stance of comprehensive sex education and its many positive effects on adolescents (Cavazos-Rehg et al., 2012; Coyle et al., 1999; Irvine, 2002; Jones, Herbert, & Mellor, 2011; Kirby, 2007; McGarry, 2013; Santelli et al, 2006; Sales, Milhausen, & DiClemente, 2006). These studies include many positive results, some of which not necessarily built into the curriculum. Direct positive results include
an increase in use of condoms and contraceptives by adolescents and a decrease in
teenage pregnancies. Other positive results also include higher perceived self-esteem,
confidence in decision-making regarding sex and sexual behaviors, an increase in feeling
relatable to peers, and increase in feelings of self-worth.

Regardless of the differences in opinions and beliefs regarding the appropriate
form of sex education in school, it is certain that abstinence-only or no sex education
models include many short and long-term risks to youth with no substantial or justifiable
benefits. The overwhelming majority of people are in favor of comprehensive sex
education in schools. The small minority, however, have continued to fight the research
and statistics on this issue and have been successful in their lobbying thus far. It is for
this reason that advocacy and education is more important than ever. Educators,
researchers, social workers, public health officials, and other professionals need to push
for the integration of comprehensive sex education nationwide today so that our
adolescents have a more successful tomorrow.

**Statement of the Research Problem**

Sexually-transmitted infections such as HIV and AIDS, teen pregnancies, gender
violence, and other such sex related issues are associated from a lack of education.
Within the United States, research has shown that a majority of people approve more
comprehensive sex education programs within schools (Dallard, 2001). Although the
majority of students currently receive sex education in the United States, it is not
comprehensive or robust enough to address the prevailing consequences that continue to
persist within society. Some research studies have tested specific curriculums pertaining
to more comprehensive sex education but they have yet to be implemented into schools nationwide. Other nations, such as The Netherlands, promote positive and comprehensive sex education programs within their schools and have some of the lowest statistics of sexually-transmitted infections, HIV and AIDS, teen pregnancies, and gender violence. This study will attempt to bring more awareness to the desires adults in the United States have regarding sex education components.

**Purpose of the Study**

The purpose of this study is to quantitatively explore what, if any, educational components and/or modules adults would recommend if they were able to create their ideal sex education curriculum. Specifically, this research study will examine the relationship, if any, between adult demographic characteristics and the sex education curriculum components they chose. The secondary purpose of this study is to further the amount of research that exists on this topic. The results of this study may also affect the micro, mezzo, and macro levels of social work.

**Research Question**

This study investigates the following research question: How do the demographic characteristics of adults affect the educational components/modules they recommend in a sex education curriculum?

**Theoretical Framework**

This study will utilize the ecological perspective. This perspective examines the ways in which the environment influences or has an impact on an individual and the ways in which that individual interacts with others. The researcher will first provide a
description on the perspective, followed by an explanation of how it may be applied to this research study.

**Ecological Perspective**

The ecological perspective was first introduced in 1868 by Ernst Haeckel, a zoologist from Germany. He coined the term “ecology” to describe the interactions of living organisms between one another and their environment. It was not until the 1970s, however, that Murray Bookchin developed the term “social ecology” to describe the ways in which individuals form interrelationships between one another and their environments (Ungar, 2002). More recently, the theory has been used to explain further the ways in which an individual and their environment continuously influence one another and where one’s environment can serve as both an obstacle and a resource for change and adaptation (Johnson & Rhodes, 2005). The ecological perspective serves as the best theoretical framework in examining both the internal and external forces of one’s environment that contribute to a particular issue, ways in which it is perpetuated, and how it might aid in providing a solution (Sands, 2001).

There are four different levels of the ecological perspective. These are: the the microsystem, mesosystem, the exosystem, and the macrosystem (Roberts, 2002). In the contexts of this particular research study, personal history may include an individual’s past experiences with sex, their identification of gender and sexual orientation, and personal values regarding sex. As the microsystem refers to the situational factors that surround the individual, the curriculum within the individual’s school would account for this. The exosystem includes both formal and informal social structures and institutions
that impact the situation. For this research study, that would include school and district policies as well as state and federal regulations. Finally, the macrosystem involves cultural values and beliefs society holds for its population. In this research study, these values and beliefs would center on the ways in which the United States holds sex both in a “moral” and explicit regard. This contributes to conservative decisions within policies as well as hyper sexuality within media. In summary, the ecological perspective explores many dimensions including individual factors, interpersonal, institutional factors, community factors, and state, federal, and local policies (Robbins, Chatterjee, & Canda, 1998).

**Application of Ecological Perspective**

The subject of sex education is a broad topic to consider. It encompasses many factors and systems. Social, psychological, biological, relational, environmental, developmental, economical, and geographical systems all influence sex education and the adolescents who are exposed to the curriculum. For this reason, ecological theory is a beneficial theory for sex education. One of the goals of ecological theory in relation to sex education is to examine the “interrelationships between multiple levels of influence…[and] the mutual bidirectional transactions between human beings and the properties of the environmental systems in which they interact” (Salazar et al., 2010, p. 553). This sort of analysis aims at predicting and interpreting sexual health outcomes for adolescents. This includes the examination of teen pregnancy rates, new reports of HIV and AIDS infections, and intimate partner violence between adolescents. As Salazar et al. points out, sexual behaviors of adolescents are not influenced by just one individual
factor. Rather, adolescents make sexual choices based on a myriad of components. In the context of the ecological theory, there are four specific systems that influence an adolescent’s sexual behavior, beliefs, attitudes, and choices. These systems are: microsystem, mesosystem, exosystem, and macrosystem.

In the microsystem of the ecological theory, the individual and personal interactions are emphasized. In regards to adolescents and their sexual behaviors, this is comprised of interactions with the individual’s family, social networks, school, church, and/or work. They are influenced by their interactions with their sexual partner’s characteristics, sexual networks, the prevalence of STIs and pregnancies within their immediate networks, peer norms for risky sexual behavior, and family and peer social support networks (Salazar et al., 2010).

In the mesosystem of the ecological theory, interrelations and connections between the microsystem factors are hypothesized (Salazar et al., 2010). For an adolescent who is considering beginning sexual contacts with others, their reasons for doing so is weighed heavily by the peers in which they are associated. If their peers have already initiated sexual contacts, it may pressure that individual to also begin their sexual interactions. Conversely, if their peers are abstaining from sexual contact, it may influence that individual to abstain as well. This rationale also applies to the other interactions an adolescent may have depending on their microsystem networks.

The exosystem of the ecological theory examines the larger social system of a particular individual and assesses the driving forces at work on, but not influenced by, that individual (Salazar et al., 2010). These sorts of factors include the community in
which the individual lives. Poverty levels, STI prevalence, and teen pregnancy rates may all serve as examples for the exosystem factors that influence or pressure an individual adolescent in their sexual values, beliefs, attitudes, and behaviors.

The final system within the ecological theory is the macrosystem. This system consists of the overall values and beliefs an individual has about any topic, subject, or relationship (Salazar et al, 2010). Such factors may be an adolescent’s religious belief structure. Another factor may be the individual’s ethnicity or culture and the ways in which sex and sexuality are valued or demeaned within that framework. An adolescent, who is very religious, may choose to abstain from having sex before marriage because their religion sees premarital sex as a sin. Conversely, an individual’s specific culture may praise raising children from a young age and an adolescent may feel pressure to begin having sex to fit within those cultural norms.

Because of all the different systems impacting an adolescent at any given moment, it is important to acknowledge their influence on youth. This is especially vital when assessing the best methods of sex education curriculum. Incorporation of the ecological theory into sex education curriculums and programs is a sound way to approach and connect with adolescents on the topics of sex and their sexuality.

**Definition of Terms**

The following terms are used throughout this research project and are relevant to sex education and curriculum components.

STD/STI – sexually transmitted disease and sexually transmitted infection (California Department of Education [CDE], 2008).
HIV – Human Immunodeficiency Virus. It is the retroviral sexually-transmitted infection that causes AIDS (Centers for Disease Control and Prevention [CDC], 2012).

AIDS – Acquired Immunodeficiency Syndrome. It is the last stage of the HIV infection and severely weakens the individual’s immune system and damages the individual’s ability to fight infections (CDC, 2012).

Abstinence-only education – sexual health education in which abstinence until marriage is taught. Abstinence is taught as the only form of birth control and STI prevention (Santelli et al., 2006).

Comprehensive sex education - Complete, accurate, positive and developmentally appropriate information on human sexuality, including abstinence, contraception, and STD protection; promotion of personal and interpersonal skills; implemented in a collaboration between parents or caretakers and teachers (Constantine, Jerman, & Huang, 2007).

LGBTQ – Lesbian, Gay, Bisexual, Transgender, and Queer (or Questioning) (Blake et al., 2001).

**Assumptions**

The following is a list of assumptions to be considered in this study. These assumptions are: (1) adults do tend to recommend and agree to providing adolescents sex education on the reproductive organs; (2) adults do not agree with the types of sex education issues to be addressed in school curriculums; (3) lack of sex education contributes to sexually-transmitted infections and rates of teen pregnancies; 4) the
environment or community in which an individual resides affects their recommendations for sex education curriculum components.

**Justification**

Sexually-transmitted infections, HIV and AIDS, and gender violence do not affect only specific groups within society. Every class, gender, race, ethnicity, and religion can be and are affected by these public health issues. Every year, these social issues cost local, state, and federal governments billions of dollars to treat these issues through medical treatments and mental health interventions (CDC, 2003; NCADVC, 2007). Teen pregnancies, too, cost the economy billions of dollars annually in medical costs and social service interventions such as food stamps and public assistance. Though it affects a smaller portion of society, its affects trickle down to tax payer dollars. In some cases, consequences to sexually-transmitted infections, HIV and AIDS, teen pregnancies, and gender violence result in death due to infections, intimate partners, and poor access to medical care.

The issue of sex education is an important topic for the social work profession. According to the National Association of Social Workers Code of Ethics, the social worker’s profession’s mission is to “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (“Code of Ethics of the National Association of Social Workers, 2008). As studies have illustrated, the well-being of adolescents is significantly impacted by their interpersonal sexual relationships with peers. Sexually-transmitted infections, pregnancies, and gender violence all impact
those relationships and, ultimately, affect adolescents’ potential for healthy adulthood. As social workers, it is fundamental to value and respect the dignity and worth of any individual and to recognize the importance of human relationships ("Code of Ethics of the National Association of Social Workers", 2008). Within the context of sex education, it is vital for social workers to advocate on the behalf of youth regarding their education needs so they can make more informed, healthy decisions about their sexual relationships with others. The issue of sex education components is important in that it has overwhelming consequences for the individual, as well as their partner, family, and society. If an individual contracts HIV or AIDS, becomes pregnant, or becomes involved in an abusive relationship, it potentially affects their ability to be successful in their life. As social workers focus on the dignity and worth of a person, it is necessary for the profession to understand the impact of sex education on adolescents. If social workers understand this connection, they can better educate those who make the decisions regarding the components that consist of sex education curriculum. By investing in this venture, it better helps those who are vulnerable and more susceptible to poor decisions regarding sex and sexual relationships: adolescents.

**Delimitations**

In this study, the relationship between sex education curriculum components/modules and adult participant demographics is examined. There are a few limitations with this study. One such limitation is that this research project does not include qualitative data to further explore possible factors or in-depth meaning related to components individuals would include in their ideal sex education that responded to the
survey. Another information is in regards to the method of collecting responses. The information retrieved is limited to individuals on the campus of the California State University, Sacramento, who walked by the researcher as she was distributing her survey and was willing to volunteer to complete the survey. This also addresses another limitation of the study. The population who filled out the surveys was most likely California State University, Sacramento students as they were surveyed on the school’s campus. This higher education level may have skewed their answers as they may have more knowledge on sex education than the general public. Another limitation of this research study is the content of the survey. Information related to education, socioeconomic status, or political views were not factored into the study. In addition, although examples were given of specific sex education curriculum components/modules, they were not defined. By omitting a definition, this may have confused the participant or the participant may have interpreted the specific component/module differently than was intended in the survey.

Summary

Chapter one is an introduction to the topic of sex education. It included a section discussing the background of the problem, a statement of the problem, the purpose of this research study and the theoretical framework of the ecological theory. In addition, Chapter one contained a section of the definition of terms as well as sections that described the assumptions, justification, and limitations of the project.

Chapter two is a review of literature on the topic of sex education. It includes a section covering a description of the historical background of sex education within the
United States. Chapter two then reviews the research on male and female reproductive systems, medical and non-medical forms of contraceptives, sexually-transmitted infections, types of romantic and sexual relationships, virtual sex practices, other factors influencing sex education, and gaps in the literature. Chapter three is a description of the methodology. In Chapter four, the data retrieved for this study is examined and analyzed. In Chapter five, the summary of the findings is presented as well as recommendations and implications for social work practice and future studies.
Chapter 2

REVIEW OF LITERATURE

This literature review will be organized in the following sections. The first section will describe a brief history of sex education in the United States, including the grade(s) in which individuals receive sex education in school. The remaining sections will describe components of sex education curriculum. The second section will describe male and female reproductive systems and the third section will cover medical and non-medical forms of contraceptives. The fourth section will report sexually-transmitted infections and the fifth section will examine different types of romantic and sexual relationships. The sixth section will discuss virtual sex practices and the seventh section will explore other factors influencing sex education. The chapter will include the gaps found in the literature and conclude with a summary.

History of Sex Education in the United States

Prior to the twentieth century, teaching sex to youth was the responsibility of the family, if they chose to do so at all (Moran, 2000). Women were taught to remain chaste until married and many men were taught about sex through male relatives who then often took them to brothels (Moran, 2003). Up until 1920, sex was viewed in moral terms of chastity and purity. These beliefs were residual effects of the Victorian era themes of sexual repression (Rury, 1987). Morality was defined by religious institutions and acts that did not fall within the institution’s parameters were labeled as sin or evil. Such acts included having sexual relations outside the sacrament of marriage and acting upon homosexual feelings (Leviticus 18:22; Meier, 2003; Rostosky, Wilcox, Wright, &
Randall, 2004). These Judeo-Christian influences were conceived between the third and sixth centuries and were the driving force behind the teachings and laws governing sex and sexuality within Western societies (Bullough, 1994). Saint Augustine, who has created much of modern day Christian doctrine, believed Christians should remain celibate throughout their lifetime. Recognizing this was not a practical application to all of society, he allowed for sex only within the context of marriage and only for the purpose of procreation (Augustine & Hunter, 1999; Bullough). These early sexual social constructs have continued to shape and influence Western civilizations through today.

Sex education only became a topic of discussion in the public realm as urbanization began spreading. Countries, such as the United States, began seeing more of the symptoms associated to sexually-transmitted infections such as syphilis and gonorrhea as individuals and families moved from farms to cities (Moran, 2003). This translated to a public health issue as infections began to spread rapidly within these cities.

As a way to combat the increasing numbers in sexually-transmitted infections, organizations like the American Social Hygiene Association (ASHA) were created. ASHA’s goal was to educate young people about the dangers of sexual activity prior to marriage. The rationale was that if young people abstained from sex prior to marriage, they would not be susceptible to contracting any sexually-transmitted infections (Clarke, 1955). Members of the organizations, such as the ASHA, also believed that incorporating sex education into schools could help in solving these new social issues (Luker, 2006).
The United States federal government became involved in sex education as a consequence of military exposure to sexually-transmitted infections during World War I. The Chamberlain-Kahn Act of 1918 was enacted to teach soldiers about syphilis and gonorrhea (Moran, 2003). This became the first time many American men were exposed to formal sex education. The film’s producer, the American Social Hygiene Association (ASHA), then adapted the film to be used within the American public school system.

Over time, members of ASHA shifted their focus to the promotion of marriage and the health risks of engaging in sexual activities outside of marriage. Later, in response to the “sexual revolution” of the 1960s and 1970s, organizations such as the Sexuality Information and Education Council of the United States (SIECUS) were created (SIECUS, 2009). Members of SIECUS developed the first ever “sex education” that diverted from moralistic agendas. Instead, members in this organization focused on “value-neutral” information that allowed students to make their own informed decisions about sex and sexuality.

As it currently stands, many states use federal funding to support their classroom discussions on this topic. Although the government began classroom sex education interventions the 1920s, it was not until 1970 when sex education became federally funded. According to Moran (2008), organizations such as the Sexuality Information and Education Council of the United States (SIECUS) were created in response to the “sexual revolution” of the 1960s and 1970s. Members of SIECUS developed the first ever “sex education” that diverted from moralistic agendas and instead focused on “value-neutral” information that allowed students to make their own informed decisions about sex and
sexuality. In 1970, the Title X Family Planning Program was created under the Public Health Services Act. The program served as the only federal grant program that aimed to provide comprehensive sexual health and family planning services (U.S. Department of Health and Human Services [USDHHS], 2009; Santelli et al., 2006). In response to the creation of SIECUS and the implementation of Title X, formerly apolitical religious activists and conservative groups congregated to voice their opposition to comprehensive sex education in schools.

By 1981, and under President Reagan, the Adolescent Family Life Act (AFLA) was created to fund grants that supported research on the negative consequences to premarital sex (Santelli et al., 2006; SIECUS, 2009; U.S. Department of Health and Human Services [USDHHS], 2009). The research examined premarital sexual relations, teen pregnancy statistics, and teen parenting. Over time, the AFLA’s focus has evolved into the focus of abstinence-only education and the prohibition of abortion (USDHHS). In addition, no program is to receive any funding if it teaches abortion as a form of contraceptive or family planning option (USDHHS). Abstinence-based education became the national standard by 1996 when the Personal Responsibility and Work Opportunities Reconciliation Act was enacted. Also known as Title V of the Social Security Act, the Personal Responsibility and Work Opportunities Reconciliation Act defined abstinence-only education and set education requirements for states who wished to receive federal funding for sex education (Hauser, 2008; Saul, 1998). States were required to teach abstinence-only outside of marriage and were prohibited to promote the different types of contraceptives or their effectiveness (Santelli et al.; Saul).
Conservative and religious influence over sex education was promoted even further in 2000 when the George W. Bush Administration came to office. Religion and faith-based acts became the main driving force behind decisions related to sex education (Solinger, 2001). The Office of Faith Based Action was created within the White House, which further advanced the agenda of Christian morality through federally funded sex education programs. This office, in conjunction to the abstinence-based program requirements under Title V of the Social Security Act, created a monopoly of conservative funding sources for states that sought out federal funds (Santelli, et al.; Solinger, 2001). In other words, no state could request or receive funding from the federal government to pay for comprehensive sex education. If states wanted to use federal funding for sex education programs within their state, they were mandated to promote abstinence-only education.

According to the SIECUS (2009), sex education programs today are divided into four types: Comprehensive Sexuality Education, Abstinence-Only Education, Abstinence-Only-Until-Marriage Education, and Fear-Based Education. Up until 2009, only those programs that promoted abstinence-only were federally funded. This translates to an abstinence-only based curriculum for the majority of states. However, many schools have recently decided to provide more comprehensive sex education for their students in lieu of accepting federal funds (Hauser, 2008). This shift has been supported by President Obama who, in 2009, cut funding to abstinence-only education.

Analysis of currently promoted education programs show that a myriad of approaches have a positive effect on the students’ behaviors (Kirby, 2007). However,
despite these different approaches, there is often a lack of research regarding the success rates based on youths’ perceptions on their education received. Further still, there has been a lack of research to show the longitudinal effects of sex education received amongst young adults. This literature review aims to analyze the research conducted on adults’ youth and young adults’ experiences of sex education received in high schools and the ways in which they perceive is most effective.

**Male and Female Reproductive Systems**

In regards to sex education, male and female reproductive systems are perhaps the most benign component. They are incorporated into abstinence-only models as well as comprehensive sex education curriculum. In more broad contexts, reproductive systems are discussed within general science courses throughout the public school system. It is often introduced within biology or anatomy classes and covers the scientific process of sperm joining a fertile egg, which leads to cell division, a viable embryo, and, finally, a baby. Sex education curriculums tend to discuss the sexual act of reproduction within biological constructs. Many overlook, minimize, or skip the sexual or relational components that lead up to reproduction (Kirby, 2007; Landry, Darroch, Singh & Higgins, 2003; Luker, 2006). Rather, sex education regarding male and female reproductive systems is reduced to a fact-based, analytical approach void of the interpersonal, developmental, or psychological aspects that are key influences on sexual behaviors.

Reproduction is a fundamental part of existence to any species. The union of sperm and egg is necessary to create life and, thus, is an acceptable topic of discussion
within society. More specifically, the topics of infants and child development are pronounced within the American culture. Education on child development is provided to educators and families through formal education, television programs, internet websites, and social interactions between adults. Discussions related to child development spill over into puberty and, finally, adulthood. Discussions regarding hormonal changes during puberty, however, begin to break down. Though some components are discussed clinically, topics related to menstruation, masturbation, and changes in secondary sex characteristics, such as genital and hair growth remain inconsistent (Kirby, 2007; Moran, 2000; Santelli et al., 2006). This does not, however, imply a complete lack of education on these topics. As early as the 1960s, sex education comprised solely of reproductive and physiological content. Young boys were taught physiology and masturbation by school athletic coaches while young girls were shown videos and discussed menstruation with their teachers (Irvine, 2002). Today, this type of “gender separation” in early sex education remains the status quo. Many fifth and sixth grade males and females are first introduced to menstruation and puberty changes in single-gender classroom settings (Kirby; Landry, Darroch, Singh, & Higgins, 2003; Santelli et al). Rarely do educators or parents discuss at length masturbation for both males and females, genital growth changes, sexual urges resulting from hormonal changes, or biological changes to the opposite gender (e.g., menstruation taught to males or “wet dreams” taught to females). Reasons for this include: imposed state or federal restrictions in sex education curriculum components, parental knowledge regarding topic, perception that students are too young to learn about or understand the sexual topic, and parental comfort level of discussing
sexually-related topics (Coyle et al., 1999; Eisen, Zellman, & McAlister, 1990; Landry, Darroch, Singh, & Higgins; Santelli et al.). Interventions within the formal education model, therefore, are crucial in responding to all of the issues related to male and female reproductive systems.

**Medical and Non-Medical Contraceptives**

Sexual contraceptives are produced and defined in many forms. For this section, they are divided between medical and non-medical variations. Medical forms of contraceptives take the form of physician prescribed methods. These include easily reversible methods such as: oral contraceptives, diaphragms, cervical caps, vaginal rings, the patch, and one-month injectable hormone contraceptives. It also includes more permanent or less easily reversible methods such as: intrauterine device (IUD), Depo-Provera (or “the shot”), an implant, vasectomy, tubal sterilization (Guttmacher, n.d.).

Non-medical forms of contraceptives include all those methods not required to have a medical prescription or procedure. These methods include: emergency oral contraceptives, male and female condoms, the withdrawal method, periodic abstinence, foam, vaginal sponges, suppository or insert, and spermicide (Guttmacher, n.d.).

Some sex education programs teach about both medical and non-medical contraceptives while others chose to focus only on a select few. Up until 2010, the States receiving federal funding for sex education were required to teach abstinence-only education. This meant that the students received education and information on using abstinence as the only way to prevent infections and unwanted pregnancies. Both
outcomes could only be achieved by abstaining from having sex until after marriage (Hauser, 2009; Moran, 2003).

Support for abstinence-only education is scarce within the peer-review community. From the research that has shown support for the model, virtuous beliefs are often described as factors motivating teenagers to wait in having sex. Teens surveyed by the National Campaign to Prevent Teen Pregnancy reported teenagers felt religion had an impact on their decisions to delay having sex (Whitehead, Wilcox, & Rostosky, 2001). These findings, however, would not be useable within the public school system as a program model due to its religious doctrine. Another abstinence-only model, Postponing Sexual Involvement (PSI), was reported to be successful in helping teenagers abstain from having sex up to 18 months after the curriculum was presented. In a review of this study, however, Bearman and Bruckner (2001), found that once the pledge was broken, these same individuals were less likely to use contraceptives or condoms.

Within the context of contraceptives, many medical and non-medical forms are included. Teaching teenagers about contraceptives is valuable in that it educates the participants on ways in which they can protect themselves from sexually-transmitted infections and unwanted pregnancy. Students appear to feel the same way about such exposure. Even within the contexts of one particular aspect of sex education, students reported the importance of school-based information regarding contraceptives and the ways in which it could be better refined to meet student needs (Jones, Biddlecom, Herbert, & Mellor, 2011).
Focusing on different types of contraceptives and their uses, for example, could increase the likelihood for teens to use them once they become sexually active. The 1988 National Survey of Family Growth showed that students who were provided education on contraceptives were more likely to use said contraceptives during intercourse compared to those who had received no education about the different types of contraceptives. In other words, condom use increased by 70-80% and the use of oral contraceptives more than doubled among teenage females (Eisen, Zellman, & McAlister, 1990; Mauldon & Luker, 1996). These statistics were especially significant as the contraceptive education provided was held during the same year in which those who participated in the study became sexually active. Teenage males who received education on different types and methods of contraceptives were also more likely to use said methods when they became sexually active. In particular, when adolescent males were educated on the ways in which condoms served as protection against STIs, AIDS, and pregnancy, they were more likely to use condoms during sexual activity (Orr & Langefeld, 1993).

**Sexually-Transmitted Infections**

The issue of sexually-transmitted infections is perhaps the most researched component of sex education. As it has historically been viewed as a public health issue, there has been a greater emphasis on this issue. The United States has some of the highest reported statistics of sexually-transmitted infections among developed nations (Stanger-Hall & Hall, 2011). Despite the country’s longstanding focus on prevention and treatment of sexually-transmitted infections, rates have remained unchanged.
Ways in which sexually-transmitted infections are taught to students vary depending on the type of sex education they are receiving. In qualitative surveys conducted by researchers, goals have included the teenagers’ perceptions of sex education as it relates to sexually-transmitted infections. In one focus group, high school students expressed a lack of interest in the repetitive education and facts received around HIV and AIDS (Hoppe et al., 2004). This leads to a potential lack in retention of the material as the students feel disconnected and unengaged from the material being discussed.

In addition, rates of sexual infections among adolescent males and females often precede the time in which students are taught about sexually-transmitted infections. By the time students are taught about sexually-transmitted infections and HIV/AIDS, between 30 and 40% of students have already been infected with one or more infections (Orr & Langefeld, 1993; Stanger-Hall & Hall, 2011; Sales, Milhausen, & DiClemente, 2006). Reviews of other sexually-transmitted infection and HIV/AIDS interventions have also yielded information pertaining to current educational trends. Sexually-transmitted infection education programs that customize their interventions to fit their audience have been found to be more successful than their generalized counterparts (Sales, Milhausen, & DiClemente). Successes also extend to those programs that emphasize contextual issues related to sexually-transmitted infections. For example, sexually-transmitted infection interventions that discussed self efficacy, problem solving, gender issues, and social skill building were shown to be more effective at reducing risk in sexual behavior (Basen-Enquist et al., 2001; Coyle et al, 1999; DiClemente et al.,
2004). These findings were consistent throughout both qualitative and quantitative research studies.

**Types of Romantic and Sexual Relationships**

Relationships, in general, encompass a broad umbrella. Within the context of sex education, these relationships are defined within romantic and/or sexual constructs. This includes both serious and casual types, monogamous and non-monogamous types of relationships.

Studies have been conducted to see if discussing relationships within sex education is effective for the learner. The results are often limited in their findings as researchers typically use very few variables to test for variances in responses. In addition, many studies pool data from multiple schools to test for quantitative differences. High-performing and low-performing schools included in the same pool of data may, therefore, obscure key differences when averaged (Adler, Kerpelman, Schramm, Higginbotham, & Paulk, 2007; Halpern-Meekin, 2012). This leads to limited results with which researchers can interpret. Conversely, qualitative research of teenagers’ experiences highlighted several key factors about their education experience. Communication, family priorities, sex, relationship prerequisites, healthy versus unhealthy relationship behaviors, and wedding/marriage preparation were all listed as major themes associated to their sex and relationship educational experience (Basen-Engquist et al., 2001; Halpern-Meekin, 2012; Sales, Milhausen, & DiClemente, 2006). These types of qualitative findings allowed researchers to more accurately interpret the most effective components of sex and relationship education within schools. Perhaps
more importantly were the teenagers’ views about their experience within the sex and relationship courses. They felt the lessons were informative, enjoyable, and helpful which provided the researchers with a better understanding of the students’ retention rates within the lessons and their willingness to be engaged in the material (Gardner, 2001; Halpern-Meekin, 2012).

Open and frank discussions in the classroom regarding types of intimate relationships are not a new concept. In some classroom settings, discussions emerged about the “difficulties commonly involved when marriage is made between differing races, religions, and nationalities; family harmony; budgeting; respect for the opposite sex; role of both sexes in family life” (Luker, 2006, p. 61). Teenagers were able to voice their concerns and talk more candidly in a setting that facilitated non-judgment and acceptance of each participant’s values and viewpoints. Program interventions in which students discussed gender, class, ethnic, and other disparities resulted in higher rates of reported self-esteem, condom use, and fewer partners (Adler-Baeder, Kerpelman, Schramm, Higginbotham, & Paulk, 2007; Gardner, 2001; Sales, Milhausen, & DiClemente, 2006).

Within the context of issues related to romantic and sexual relationships, additional discussion is needed regarding those who identify as Lesbian, Gay, Bisexual, Transgender, and/or Queer (LGBTQ). According to a study conducted by Blake et al., (2001), LGBTQ youth “reported more substance use, high-risk sexual behaviors, suicidal thoughts or attempts and personal safety issues than did heterosexual youths” (p. 940).
Coinciding with these behaviors, rates of HIV/AIDS have remained high amongst those who identify as LGBTQ.

Intervention programs aimed on educating LGBTQ youth on HIV/AIDS, sexual assaults, and risky sexual behavior have been narrowly focused. Programs within or outside the school environment have focused on reducing sexual risk behavior without incorporating other environmental or internal factors such as psychological stress, bullying, or sexual identity (Blake et al., 2001; McGarry, 2013; Rotheram-Borus, 1995). Sex education curriculums provided in school often exclude positive role model representatives within the LGBTQ community and, consequently, teenagers report knowing very little or nothing positive about their LGBTQ peers (McGarry, 2013). LGBTQ youth who were not provided with gay-sensitive HIV education within their schools were at greater risk of sexually-transmitted infections, HIV/AIDS, suicide, and pregnancy. Conversely, LGBTQ youth who received gay-sensitive HIV instruction programs within their schools reported lower sexual risk behaviors and greater self esteem (Blake et al.). Incorporation of gay-sensitive curriculum into any sex education program can provide positive sexual, interpersonal, and health consequences for LGBTQ youth as well as their heterosexual counterparts (McGarry).

Virtual Sex Practices

Virtual sex is a relatively new genre of sex. It is made possible by the inventions of the internet, personal computers, and cell phones. Virtual sex practices are the newest components to an ever-evolving topic (Howe, 2012; Kahn & Cerf, n.d.). Camera phone pictures and video, texting (a.k.a. sexting), and internet pornography are all forms of
virtual sex. Since the internet’s surge in popularity and accessibility in the mid 1990s, users have gained the ability to access any piece of information at any time (Landry, Gonzales, Wood, & Vyas, 2013). This new phenomenon has garnered the attention of youths and adults alike. For the first time in history, individuals have been able to look up information about sex, regardless of the source’s credibility. This has led to an incredible, yet dangerous, arena for individuals to become educated. When it comes to matters of sex, internet users are able to access information that is educational and accurate just as easily as they are able to view gender-insensitive or sexually violent videos. Both variations of information may be viewed as useful to the sexually curious individual (Sabina, Wolak, & Finkelhor, 2008; Wolak, Mitchell, & Finkelhor, 2007).

Modern pornography, the oldest of the virtual sex practices, has its roots in print and film (Pappas, 2010). However, with the invention of the internet, pornography can easily be accessed from the user’s own home at any time. The internet user can view images of sex, videos of specific sexual themes, join sexually-explicit chat rooms, and a myriad of other options all for free. As researchers struggle to catch up to this new form of sexual exposure, there are few empirical studies to examine its effects on its users.

In general, research has found strong correlations between pornography and increased risk for sexual perpetration, difficulties regarding intimate relationships, and acceptance of the rape myth (i.e., blaming the victim for the crime or beliefs that trivialize the rape) (Vega & Malamuth, 2007). These findings reflect attitudes men have about women after having been exposed to internet pornography at least four hours a week for several weeks. The findings imply a skewed education learned by men about
gender roles within sexual and intimate relationships as well as misunderstandings and interpretations about consensual sex (Vega & Malamuth).

With pornography now being available via the internet and so accessible, it is important to discuss the accessibility of it to minors. In a 2008 study, researchers recorded that 93.2% of teenaged males and 62.1% of teenaged females, ages 14-17, viewed online pornography prior to the age of 18 (Sabina, Wolak, & Finkelhor, 2008). Many of these individuals reported seeking out internet pornography to gain information about sex and sex practices. Their education on sex, self-image, gender roles, and cultural norms were examined through an often inaccurate portrayal of sex and relationships.

Attached to the world of virtual sex are virtual dating practices (Alvarez, 2012; Epstein, 2007). Communication technology has quickly become a standard way in which individuals form, maintain, and dissolve relationships. A recent study by Bergdall, Kraft, Andes, Carter, Hatfield-Timajchy, et al. (2012) concluded that “cell phones, text messages, and mobile internet were the most common forms of communication technology used for partnering goals” (p. 570). Participants in the study used technology to screen potential partners, get to know them, and even to break up. Studies like this confirm the importance of incorporating virtual sex into sex education curriculum. As teenagers and young adults rely on communication technology as a romantic and sexual relationship tool, it is important for educators to provide accurate information on the advantages and disadvantages of this type of information (Alvarez, 2012).
**Other Factors Influencing Sex Education**

Current abstinence-only models are based predominately on the idea of morality. This belief is closely tied to religion. As discussed earlier, religious and moral beliefs have historically influenced the content and extent of sex education taught within the United States. Specifically, in states where religion is reported to be higher or of greater importance, teen birth rates are also higher (Cavazos-Rehg et al., 2012). This may be due to personal religious beliefs, community religious beliefs, or institutional religious or conservative beliefs (e.g., stricter abortion laws). As Meier (2003) points out, attitudes regarding sex are largely influenced by religious beliefs, which may help to explain the former study results. When Meier examined longitudinal studies regarding religiosity and attitudes about sex, she was able to determine a significance regarding when adolescents had their first encounters with sex. Though religion is only one influential factor in sex education, it can serve as a crucial authority for adolescents.

The community in which one lives also has an impact on access to sex education. The characteristics of the community can facilitate or hinder an individual’s ability to receive sex education. In a study conducted by Kraft, Kulkarni, Hsia, Jamieson, and Warner, (2012), the researchers found such disparities in access to education based on community constructs. For those who lived in communities with the lowest percentages of Associate’s degrees, 75% of respondents reported receiving sex education by the age of 15 (Kraft, Kulkarni, Hsia, Jamieson, & Warner). This was a statistically significant contrast to communities on the other end of the spectrum. Those communities with the highest reported numbers of Associate’s degrees reported an 87% rate of sex education
received by the age of 15 (Kraft, Kulkarni, Hsia, Jamieson, & Warner). Similar findings were made when cross-referenced with male unemployment or median family income. In communities whose numbers fell within middle quartiles, respondents to the study reported a higher likelihood of using contraceptives once they became sexually active (Kraft, Kulkarni, Hsia, Jamieson, & Warner). This suggests that those who reside in least-advantaged communities are less likely to receive formal sex education. Conversely, those individuals who reside in the most advantaged communities are more likely to receive formal sex education.

A similar study reported that regions within the United States have an impact on the types and content of the sex education that is delivered in school systems. Landry, Darroch, Singh, and Higgins (2003) found that abstinence-only education was more common in the South than the Northeast at 30% and 17% respectively. Individuals who received sex education in the Northeast also received more information on the effectiveness of contraceptives than any other region (Landry, Darroch, Singh, & Higgins). The literature suggests that, although there are federal standards in place, sex education varies between regions, religious affiliations, and within communities.

Another component that effects sex education is the culture of sex within society. Research has shown that teenagers do not just find their information about sex from their schools. Rather, they receive information about sex from their parents, peers, the internet, television, teachers, and their community. Even current comprehensive sex education models do little to incorporate all these other integral pieces into the curriculum. Yet, in countries such as the Netherlands, where sexually-transmitted
infections and teen pregnancy are incredibly low compared to the United States, teaching teenagers about sex as a right within the culture has proved beneficial (Gianotten, 1998). By shifting beliefs about sex within the culture to be more positive, inclusive, and respectful, teenagers have benefited from low sexually-transmitted infections and unwanted pregnancies despite their initial age of intercourse coinciding with teenagers in the United States.

Finally, the age to teach sex education, the duration of each session, the overall length of the program model, and the training instructors receive are all factors that contribute to the effectiveness of sex education. Currently, many schools concentrate their sex education to grades seven through nine and integrate it into health or science classes already being taught (Berne & Huberman, 1999). The average duration of the sex education is five classes with little or no training provided to the instructors (Berne & Huberman, 1999). Instructors are not always given formal training about sex education nor are they required to have any pre-existing knowledge on the topics discussed. As a result, students report feeling disengaged from the material or less likely to ask questions about topics being discussed.

**Gaps in the Literature**

As sex education continues to evolve, so do the requirements for more rigorous program evaluations. There is little to no current research on the longitudinal effects of any kind of sex education. Current measures are designed to cross-reference sexually-transmitted infections and teen pregnancy rates as reported by the Center for Disease Control (CDC) with current sex education programs. As rates of infection or pregnancy
increase, the current programs administered are analyzed and labeled as having a
correlation to these trends. If current models require abstinence-only education
components, research studies looking at current rates of sexually-transmitted infections
compare the two for potential correlation. If rates of infection have increased, it might be
inferred that abstinence-only education models are ineffective. This does little to no good
in tracking specific sex education program designs and their long-term effects on the
recipients (Basen-Engquist et al., 2001; Eisen, Zellman, & McAlister, 1990; Kirby, 2007;
Sales, Milhausen, & DiClemente, 2006). By limiting the scope of focus or comparison, it
omits the statistics related to adulthood reports of sexual activity, violence, and health.

Another such issue related to research on sex education is convenience sampling.
As research regarding sex education curriculum is largely based on individuals ages 17 or
younger, it is more difficult to obtain consent. Therefore, many studies conducted
regarding sex education curriculum and its components rely on retrospective reports or
consent obtained by parents of minors who are willing for their children to discuss topics
related to sex (Adler-Baeder et al., 2007; DiClemente et al., 2004; Sabina, Wolak, &
Finkelhor, 2008; Wolak, Mitchell, & Finkelhor, 2007). Convenience sampling, therefore,
may influence the results of some sex education research studies as the responses by
participants are potentially subjective or bias.

As adolescents are increasingly able to access information through the Internet,
cell phones, and other devices, it is more vital than ever to discuss how these connections
intersect sexuality and sex education. As this sub-section of sex education is rapidly
evolving, there is a lack of standardized procedures and inquiry techniques in obtaining
the data. Therefore, more standardized research techniques are needed to more effectively quantify and interpret data from research studies that examine technology and sexuality and the ways in which these intersect with interpersonal relationships (Adler-Baeder et al., 2007; Alvarez, 2012; Bergdall et al., 2012; Gardner, 2001; Wolak, Mitchell, & Finkelhor, 2007). As these measures become more standardized, so may the validity and reliability of the results.

This research study seeks to address the gap regarding the relationship between demographic characteristics of adults and the ways in which those characteristics affect sex education curriculum recommendations. Current research studies do not address the ways in which gender or age influence an individual’s opinion regarding sex education. This research study aims to add to the current literature by exploring the potential relationship between these variables.

Summary

In this chapter, the historical background of sex education was described. In addition, the following sections were also discussed: male and female reproductive systems, medical and non-medical contraceptives, sexually-transmitted infections, types of romantic and sexual relationships, virtual sex practices, and other factors influencing sex education. Finally, this chapter concluded with gaps in the literature. The next chapter will focus on the methodology of the current study.
Chapter 3

METHODS

In this chapter, the methodology and research design will be described, including the research question, the study design, the independent and dependent variables studied, and the study population. It will also include a review of the sample population used, instrumentation, and data collection procedures. A review of human subjects procedures and protections as well as a summary will also be included.

Research Question

This study examines the following research question: How do the demographic characteristics of adults affect the educational components/modules they recommend in a sex education curriculum?

Study Design

This study is an exploratory quantitative cross-sectional survey research design, utilizing a brief survey instrument. This is considered a quantitative study because the researcher is attempting to describe phenomena and analyze the numerical data collected rather than observations or interviews (Royse, 2008).

This study employs an exploratory survey research design as it addresses a topic for which minimal data is available. The purpose for using the exploratory survey research design in this study relates to the unstudied topic of the recommendations adults have for sex education components/models.

There are several advantages to using a survey research design (Rubin & Babbie, 2001). First, collecting data through surveys is valuable in that it gathers information
about people’s attitudes, feelings, beliefs, behaviors, and lifestyles (Royse, 2008).

Second, the responses received through survey research can then be generalized to the larger population. Third, survey research is valuable in that its findings may then generate additional research questions and hypotheses to be explored (Royse, 1999). Fourth, survey research is valuable in that it examines potential relationships between characteristics of the respondents and their beliefs, values, or opinions reported on the survey (Royse, 2008). Additionally, factors inherent to the respondent such as age, gender, ethnicity, or social class may have an influence on their attitudes or beliefs toward certain social issues.

Rubin and Babbie (2001) have noted that survey research designs have inherent strengths and weaknesses. Strengths in survey research designs include increased external validity: the ability to generalize the results of the study to a larger population. Survey research studies are also useful in describing large populations as they allow very large samples to be gathered. This advantage is due to the simple and cost-effective means of obtaining information from a large group of people through surveying. In this study, for example, it would be extremely difficult to research the sex education recommendations of adults from all over the United States by any other means but a survey. The large samples feasible through survey research allow for more accurate descriptive analysis of variables, as well as analysis of multiple variables simultaneously (Marlow, 2005). This is important for this study given the number of independent variables being examined.
While there are many advantages to using an exploratory research design, there are some drawbacks to consider. One such disadvantage is that exploratory research lacks a conclusive outcome and thus requires further research (Rubin & Babbie, 2001). Another disadvantage is the inability of the survey to fully express the array of human experiences due to the specific categories predefined by the researcher. Finally, this type of design is limited in that the sample population is small and thus is limited in its representation of the population as a whole as well as its generalizability (Dudley, 2011). That being said, this study may aid in discovering and identifying pertinent information that can then be further explored in studies regarding best practices in sex education content.

**Variables**

The independent variables for this study include the following: gender, age, race/ethnicity, and whether or not the respondent received sex education while in school. The dependent variable is the perceptions respondents have of the sex education they received and what, if any, recommendations they have for future curriculum topics in school using the list of topics provided by the researcher.

The level of measurement of the independent variables (demographics of respondents) is nominal. The level of measurement for the dependent variable (recommendations for sex education topics) is ordinal.

**Study Population**

The population for this study included individuals from the California State University, Sacramento campus. Any individual who passed through the University
Union quad area while the survey was being handed out was invited to participate. The researcher collected survey responses from 30 individuals who agreed to participate in the survey. The study population included 13 male participants and 17 female participants. The population included various ethnic/racial backgrounds and ages.

**Sampling Population**

A non-probability, convenience sampling design method was used in this study to obtain the sample population. The subjects for this sample were selected solely based on their presence on the California State University, Sacramento campus at the time of the survey disbursement. Due to the need to generalize on this particular topic, it would be ideal to study sex education recommendations of individuals on a national scale. It would be quite expensive, though, to contact people across the United States to be included in this study. For the purposes of collecting opinions on sex education recommendations, a non-probability, convenience sampling method was determined to be sufficient because of funding limitations in carrying out any other type of sampling design.

According to Royse (2008), there are several advantages and disadvantages to using convenience sampling. One such advantage to using convenience sampling is that the method is cost-effective. Another advantage to using convenience sampling is that the method often allows studies to be conducted very quickly. A third advantage is that convenience sampling is easy to conduct.

Though there are several advantages to using convenience sampling, there are also a few disadvantages. One such disadvantage is participant bias (Royse, 2008).
Should a participant know the researcher conducting the study, they may not answer as honestly. One other disadvantage of convenience sampling is the population itself. If a researcher is conducting surveys with peers, friends, or colleagues, that sample population may not represent the viewpoints of the larger population. Common interests, goals, or values may influence their responses.

**Instrumentation**

Surveys were conducted with each individual who received and reviewed a consent document (See Appendix A) and survey instrument (See Appendix B). Participants were recruited using a verbal recruitment script recited by the researcher (See Appendix C). The survey instrument used for this study was developed by the researcher based on current sex education curriculums being taught in the United States (Eisen, Zellman, & McAlister, 1990; Gardner, 2001; Irvine, 2002; Santelli et al., 2006; Stanger-Hall & Hall, 2011). Some additional variables regarding sex education were added by the researcher based on known international sex education models being taught and current human sexuality topics (Berne & Huberman, 1990; Gianotten, 1998).

Participants in this study were asked to complete a written survey designed to measure the recommendations individuals have for future sex education curriculum. There were two sections identified in this survey. The first section pertained to the demographics of the participants filling out the survey. This included whether or not the participant had received sex education; and, if so, the grade in which it was received. Also, participants were asked to determine their perception of the appropriateness in timing of the grade in which sex education was received using a Likert scale format. The
second section of the survey included a list of recommended topics participants could choose from if they were to create an ideal sex education curriculum.

As there has been a limited amount of research conducted on adults’ recommendations for sex education curriculum, the survey instrument used in this study is a non-standardized instrument developed by the researcher who utilized the literature on this topic for its development. This type of instrument may, therefore, demonstrate decreased external validity (Rubin & Babbie, 2001). However, the researcher sought to minimize these potential issues by consulting with the division of Social Work faculty experts to determine the validity of the questions asked in the survey instrument. Similarly, this survey has not been tested for reliability.

Data Collection Procedures

Participants in this study were recruited by the researcher standing in the University Union quad of the California State University, Sacramento campus. Potential participants were asked to take part in the survey as they walked past the researcher. If volunteers agreed to participate, they were handed the survey materials, which included the consent form and survey questions. The consent form also indicated that completion of the survey implied their consent to participate in the research study.

Participants were informed they would receive an honorarium in the form of a condom or some candy for completing the survey. Surveys were then completed while the researcher stood at least six feet away from the participant to maintain their privacy and confidentiality. At the end of the survey, the participants placed their survey questionnaire faced down in a box provided by the researcher to avoid any identification
of themselves to the researcher of who had completed the survey. Participants were then
directed to take a condom or a piece of candy from baskets located next to the survey
box. Any conflicts of interest as a researcher were avoided, as the researcher did not
know the identities of those who chose to participate in the survey.

**Data Analysis**

Once all the completed surveys were gathered, the researcher entered the data into
the SPSS program. The variables were then statistically analyzed using univariate
analysis and bivariate analysis. Univariate analysis included frequency distribution tests,
descriptive statistics, and charts to describe the distribution of the variables in the study.
Bivariate analysis (chi-square) was then used to examine the relationship between the
independent variables (participant demographics) and dependent variables (sex education
recommendations). Multivariate analysis (i.e., logistic regression) was also used to
determine which topics, if any, in sex education were perceived to be the most beneficial
in future sex education curriculums.

**Protection of Human Subjects**

Prior to collecting data for this research study, the study was approved as exempt
by the California State University, Sacramento Division of Social Work Human Subjects
Committee. The survey questions posed no known risks to the participants. The
subject’s rights to privacy were protected because the survey responses provided to the
researcher were kept confidential. Surveys were placed in an enclosed box by the
participants themselves to further ensure and maintain privacy and confidentiality.
Potential participants were required to read a consent document (Appendix A) prior to completing the survey. The consent document indicated that participation in the study was completely voluntary and that they could stop their participation at any time. The consent form also detailed information regarding the purpose of the study as well as notifying the participant that completing and returning the survey implied their consent. Contact information for the researcher and the researcher’s thesis advisor was also provided in the event the participant had any further questions after completing the survey.

Summary

This chapter discussed the quantitative research methods that were used in this research study. It included the purpose, design, and methodology of the research study. The study population was described as well as the way in which the sample population was obtained by the researcher. The chapter then described the survey questionnaire used for this study and how the data gathered was analyzed. The protection of human subjects was outlined as well as assurances to ethical practices in research involving human subjects. The results of the data gathered will be presented and analyzed in the following chapter.
Chapter 4

DATA ANALYSIS

This chapter examines the results of the research study. The demographics of the participants will be examined as well as the responses of the participants as to their own experiences with sex education in school as well as their recommendations for future sex education components. Statistically significant results will be examined using chi-square analysis with a p-value of less than .05. Data with a p-value between .05 and .10 will also be examined and discussed as trend level data. Data was analyzed using Chi-square, Fisher’s Exact Test to determine statistical significance within variables.

Several responses were recoded for chi-square analysis. The responses for the variable “age” were recoded to: 18-29 and 30+ years. The responses for the variables “condom use” “female birth control,” “types of romantic and sexual relationships,” “sexual self-esteem and well-being regarding sex,” “LGBTQ,” and “other safe sex practices” were recoded to 8 weeks or less and more than 8 weeks. The responses for the variable “appropriateness of grade in which I received sex education” were recoded to appropriate timing or a couple of years too early and a couple of years too late. The responses for the variable “pregnancy” were recoded to 7 weeks or less and more than 7 weeks. Chi-square tests will be presented on the relationship between variables. This chapter will conclude with a summary.

Demographics

A total of 30 people participated in this research study. Participants were unequally split between genders. There were 17 female (56.7%) and 13 male (43.3%)
participants (Table 4.1). About one-quarter of participants were ages 18-24 (26.7%) and another one-quarter of participants were ages 25-29 (23.3%). Exactly one-tenth of participants were ages 30-34 (10%) and participants whose ages were 35+ accounted for the remaining 40% (Table 4.2). About three-quarters of the participants identified as Caucasian/White (73.3%) and 10% identified as “Other,” not specified. There were very few other ethnic groups that participated in the study and no participant identified as more than one ethnicity (Table 4.3). Out of the 30 participants who completed the survey on recommendations for sex education curriculum components/modules, all but one believed sex education should be taught within schools. Therefore, the following results reflect the recommendations of the remaining participants (N=29).

Table 4.1

**Gender**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>43.3</td>
<td>43.3</td>
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<tr>
<td>Female</td>
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<tr>
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</table>

Table 4.2

**Age**

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</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
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<td>26.7</td>
<td>26.7</td>
<td>26.7</td>
</tr>
<tr>
<td>25-29</td>
<td>7</td>
<td>23.3</td>
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<tr>
<td>30-34</td>
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<td>60.00</td>
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<td>35+</td>
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<td>Total</td>
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</tr>
</tbody>
</table>
Table 4.3

Race/Ethnicity

<table>
<thead>
<tr>
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<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
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<td>Asian-American</td>
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<td>6.7</td>
<td>10.0</td>
</tr>
<tr>
<td>Caucasian/White</td>
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<td>73.3</td>
<td>73.3</td>
<td>83.3</td>
</tr>
<tr>
<td>Latino</td>
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<td>6.7</td>
<td>6.7</td>
<td>90.0</td>
</tr>
<tr>
<td>Other</td>
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<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>100</td>
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</tr>
</tbody>
</table>

**How do the demographic characteristics of adults affect the educational components/modules they recommend in a sex education curriculum?**

This section will explore the relationship between demographic characteristics of adults and their recommendations for components/modules in a sex education curriculum. The statistically significant relationship between gender and condom use, gender and female birth control options, gender and types of romantic and sexual relationships, sexual self-esteem and well-being regarding sex, and gender and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) will be discussed. The statistically significant relationship between gender and appropriateness of grade in which the participant received sex education will also be discussed.

**Gender and condom use**

The independent variable gender was analyzed with the dependent variable condom use to determine a possible relationship between the two variables. A statistically significant association was found between gender and condom use ($\chi^2 = 8.191; \text{df}=1; p=.008$). Almost all of the male participants reported thinking condom use should
be taught to students for less than 8 weeks (83.3%) while 70% of females reported thinking condom use should be taught for more than 8 weeks. The 1-sided p-value of .006 and the 2-sided p-value of .008 from the Fisher’s Exact Test indicate the relationship between the two variables is significant (Table 4.4).

**Gender and female birth control**

A statistically significant relationship was found between the independent variable gender and the dependent variable female birth control after conducting a Chi-square test ($\chi^2 = 6.564; \text{df}=1; p= .022$). Nearly all male participants (83.3%) reported teaching about female birth control options (e.g., vaginal ring, oral contraceptives, hormone injections) taking place for 8 weeks or less in a sex education curriculum. Conversely, nearly all female participants (84.6%) reported teaching about female birth control options for more than 8 weeks in a sex education curriculum. The 1-sided p-value of .013 and the 2-sided p-value of .022 indicate a statistically significant relationship between the two variables (Table 4.5).
Table 4.4

*Gender and the Recommendations for Teaching Condom Use in a Sex Education Curriculum in Weeks*

<table>
<thead>
<tr>
<th></th>
<th>8 Weeks or Less</th>
<th>More than 8 Weeks</th>
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</tr>
</thead>
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<tr>
<td>Gender</td>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>% within Gender</td>
<td>83.3%</td>
<td>16.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Condom Use</td>
<td>66.7%</td>
<td>14.3%</td>
<td>41.4%</td>
</tr>
<tr>
<td>% of Total</td>
<td>34.5%</td>
<td>6.9%</td>
<td>41.4%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>% within Gender</td>
<td>29.4%</td>
<td>70.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Condom Use</td>
<td>33.3%</td>
<td>85.7%</td>
<td>58.6%</td>
</tr>
<tr>
<td>% of Total</td>
<td>17.2%</td>
<td>41.4%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>15</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>% within Gender</td>
<td>51.7%</td>
<td>48.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Condom Use</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% of Total</td>
<td>51.7%</td>
<td>48.3%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Table 4.5

*Gender and the Recommendations for Teaching Female Birth Control Options in a Sex Education Curriculum in Weeks*

<table>
<thead>
<tr>
<th></th>
<th>8 Weeks or Less</th>
<th>More than 8 Weeks</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Gender</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>% within Gender</td>
<td>83.3%</td>
<td>16.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Female Birth Control</td>
<td>62.5%</td>
<td>15.4%</td>
<td>41.4%</td>
</tr>
<tr>
<td>% of Total</td>
<td>34.5%</td>
<td>6.9%</td>
<td>41.4%</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>% within Gender</td>
<td>35.3%</td>
<td>64.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Female Birth Control</td>
<td>37.5%</td>
<td>84.6%</td>
<td>58.6%</td>
</tr>
<tr>
<td>% of Total</td>
<td>20.7%</td>
<td>37.9%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>% within Gender</td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within Female Birth Control</td>
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<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% of Total</td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Gender and types of romantic and sexual relationships

When asked about teaching different types of romantic and sexual relationships in a sex education curriculum, most male participants (83.3%) reported that it should be taught for 8 weeks or less. The majority of female participants (84.6%), on the other hand, reported that different types of romantic and sexual relationships should be taught for more than 8 weeks in a sex education curriculum. There was a statistical significant association between the two variables ($\chi^2 = 6.564; df=1; p=.022$) with a 1-sided p-value of .013 and 2-sided p-value of .022 (Table 4.6).
Table 4.6

**Gender and the Recommendations for Teaching Various Types of Romantic and Sexual Relationships in a Sex Education Curriculum in Weeks**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>8 Weeks or Less</td>
<td>More than 8</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>10</td>
<td>2</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>% within Gender</td>
<td>83.3%</td>
<td>16.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% within Types</td>
<td>62.5%</td>
<td>15.4%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of Romantic and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Relationships</td>
<td></td>
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<tr>
<td></td>
<td>% of Total</td>
<td>34.5%</td>
<td>6.9%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Count</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>35.3%</td>
<td>64.7%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% within Types</td>
<td>37.5%</td>
<td>84.6%</td>
<td>58.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Romantic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Sexual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>% of Total</td>
<td>20.7%</td>
<td>37.9%</td>
<td>58.6%</td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>16</td>
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<tr>
<td>% within Gender</td>
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<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Romantic</td>
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<td></td>
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<tr>
<td>and Sexual</td>
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<td>Relationships</td>
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<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
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<td></td>
</tr>
</tbody>
</table>

**Gender and sexual self-esteem and well-being regarding sex**

The relationship between gender and sexual self-esteem and well-being regarding sex was examined. Of the 13 male who responded to the survey, 10 (83.3%) reported the recommendation that sexual self-esteem and well-being regarding sex be taught for 8 weeks or less. Contrary to male recommendations, most females who responded to the survey recommended sexual self-esteem and well-being should be taught for more than 8
weeks (85.7%). Both Chi-square analysis and Fisher’s Exact Test were conducted to determine significance. There was a statistically significant relationship between the two variables ($\chi^2 = 8.191; \text{df}=1; \ p=.008$) due to a 1-sided p-value of .006 and a 2-sided p-value of .008 (Table 4.7).

**Gender and lesbian, gay, bisexual, transgender, and queer (LGBTQ) topics**

There was a statistically significant relationship between gender and the responses regarding lesbian, gay, bisexual, transgender, and queer topics being taught within a sex education curriculum. Of those surveyed, most male respondents (83.3%) reported that LGBTQ topics should be taught for 8 weeks or less within a sex education curriculum. Nearly two-thirds of female respondents (64.7%) reported that topics related to the LGBTQ community should be taught for more than 8 weeks within a sex education curriculum. This relationship was significant using Chi-square analysis ($\chi^2 = 6.564; \text{df}=1; \ p=.022$) and Fisher’s Exact Test, the 1-sided p-value of .013 and 2-sided p-value of .022 indicated a significant relationship between gender and LGBTQ topics (Table 4.8).
Table 4.7

*Gender and the Recommendations for Teaching Sexual Self-Esteem and Well-Being*

*Regarding Sex in a Sex Education Curriculum in Weeks*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
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<th>More than 8 Weeks</th>
<th>Total</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>2</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
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<td>16.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% within Sexual Self-Esteem</td>
<td>66.7%</td>
<td>14.3%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>34.5%</td>
<td>6.9%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>12</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>29.4%</td>
<td>70.6%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% within Sexual Self-Esteem</td>
<td>33.3%</td>
<td>85.7%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>17.2%</td>
<td>41.4%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>51.7%</td>
<td>48.3%</td>
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<tr>
<td>% within Sexual Self-Esteem</td>
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<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>51.7%</td>
<td>48.3%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Gender and appropriateness of grade in which individual received sex education**

All participants who filled out the survey responded to the question regarding the timing of the sex education they received in school (N=30). However, most 26 (86.7%) participants reported having received sex education while in school. Three-fifths of males (61.5%) who reported having received sex education while in school also reported that they believed they received sex education a couple of years too late. Conversely, over two-thirds of female participants (68.8%) reported that they felt they received their
sex education at an appropriate time or a couple of years too early. This association was significant using chi-square analysis with a Fisher’s Exact Test ($\chi^2 = 5.850; \text{df}=1; p=.041$) (Table 4.9).

**Gender and other safe sex practices**

The independent variable gender did not show a statistically significant relationship between the dependent variable other safe sex practices. However, the variable gender showed trend data as it related to the dependent variable of other safe sex practices. Of those surveyed, almost two-thirds of females (64.7%) reported other safe sex practices, such as spermicide, sponges, withdrawal, and masturbation, should be taught to students for more than 8 weeks within a sex education curriculum. Three quarters of the males, on the other hand, mostly reported that other safe sex practices should be taught for 8 weeks or less within a sex education curriculum. This relationship was approaching significance with Fisher’s Exact Test showing a 2-sided p-value of .060 (Table 4.10).
Table 4.8

Gender and the Recommendations for Teaching Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Topics in a Sex Education Curriculum in Weeks

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>8 Weeks or Less</th>
<th>More than 8 Weeks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>2</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>83.3%</td>
<td>16.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>62.5%</td>
<td>15.4%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>34.5%</td>
<td>6.9%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>35.3%</td>
<td>64.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>37.5%</td>
<td>84.6%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20.7%</td>
<td>37.9%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>13</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.9

*Gender and the Belief Regarding the Appropriateness of Timing of the Sex Education They Received in School*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Appropriate timing or a couple of years too early</th>
<th>A couple of years too late</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
<td>38.5%</td>
<td>61.5%</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>84.6%</td>
<td>15.4%</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>61.5%</td>
<td>38.5%</td>
<td>26</td>
</tr>
</tbody>
</table>

Chi-square analysis was used to examine the relationship between gender and pregnancy. Over two-thirds of females (70.6%) indicated on their surveys the
recommendation to teach students about pregnancy in a sex education curriculum for more than 7 weeks. However, two-thirds of males reported the recommendation for pregnancy to be taught within sex education for 7 weeks or less. The chi-square analysis reported no significant relationship between the two variables ($\chi^2 = 5.850; \text{df}=1; \text{p}=0.067$). The two-sided p-value indicated that the two variables were approaching significance in trend-level data (Table 4.11).

**Age and types of romantic and sexual relationships**

The independent variable of age showed trend-level data in relationship to types of romantic and sexual relationships. Nearly three-fourths of those whose ages are 18-29 recommended that types of romantic and sexual relationships should be taught for 8 weeks or less in a sex education curriculum. By contrast, almost two-thirds of those whose ages are 30+ reported the recommendation for types of romantic and sexual relationships to be taught for more than 8 weeks. Chi-square analysis showed no significant relationship between the two variables ($\chi^2 = 4.144; \text{df}=1; \text{p}=0.066$) but the 2-sided p-value .066 indicates approaching significance in trend-level data (Table 4.12).
Table 4.10

*Gender and the Recommendations for Teaching Other Safe Sex Practices in a Sex Education Curriculum in Weeks*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>8 Weeks or Less</th>
<th>More than 8 Weeks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>9</td>
<td>3</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>75.0%</td>
<td>25.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% within Other Safe Sex Practices</td>
<td>60.0%</td>
<td>21.4%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>31.0%</td>
<td>10.3%</td>
<td>41.4%</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>6</td>
<td>11</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>35.3%</td>
<td>64.7%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% within Other Safe Sex Practices</td>
<td>40.0%</td>
<td>78.6%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>20.7%</td>
<td>37.9%</td>
<td>58.6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count</td>
<td>15</td>
<td>14</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>% within Gender</td>
<td>51.7%</td>
<td>48.3%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% within Other Safe Sex Practices</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>% of Total</td>
<td>51.7%</td>
<td>48.3%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.11

*Gender and the Recommendations for Teaching Pregnancy in a Sex Education Curriculum in Weeks*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>7 Weeks or Less</th>
<th>More than 7 Weeks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>66.7%</td>
<td>33.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Pregnancy</td>
<td>61.5%</td>
<td>25.0%</td>
<td>41.4%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>27.6%</td>
<td>13.8%</td>
<td>41.4%</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>5</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>29.4%</td>
<td>70.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Pregnancy</td>
<td>38.5%</td>
<td>75.0%</td>
<td>58.6%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>17.2%</td>
<td>41.4%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Count</td>
<td>13</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>% within Gender</td>
<td>44.8%</td>
<td>55.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Pregnancy</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>44.8%</td>
<td>55.2%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Table 4.12

Age and the Recommendations for Teaching Various Types of Romantic and Sexual Relationships in a Sex Education Curriculum in Weeks

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>8 Weeks or Less</th>
<th>More than 8 Weeks</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td>73.3%</td>
<td>26.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Types of romantic and sexual relationships</td>
<td>68.8%</td>
<td>30.8%</td>
<td>51.7%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>37.9%</td>
<td>13.8%</td>
<td>51.7%</td>
</tr>
<tr>
<td>30+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td>35.7%</td>
<td>64.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Types of romantic and sexual relationships</td>
<td>31.3%</td>
<td>69.2%</td>
<td>48.3%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>17.2%</td>
<td>31.0%</td>
<td>48.3%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% within Age</td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% within Types of romantic and sexual relationships</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
<td>55.2%</td>
<td>44.8%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Summary

In this chapter, the demographics of the participants of this research study were presented. The descriptive statistics were also presented. This chapter has demonstrated the statistically significant associations between the independent variable gender and several dependent variables. These dependent variables include: condom use, female birth control methods, other safe sex practices, various types of romantic and sexual relationships, sexual self-esteem and well-being regarding sex, and LGBTQ topics. This
chapter also explored the statistically significant relationship between gender and the perceived appropriateness of timing of sex education the participants received in school. In addition, this chapter examined trend-data regarding the relationships between gender and other safe sex practices as well as gender and pregnancy. Trend-data between age and types of romantic and sexual relationships was also discussed. The next chapter will analyze the data gathered and present the conclusions, limitations of the research study, and implications for social work practice, policy, and future research.
Chapter 5

CONCLUSIONS

This chapter summarizes the main findings gathered in the study. The demographics of respondents were used to compare the ways in which they influence recommendations for sex education curriculum components/modules. This chapter also includes an explanation of the advantages and limitations of the study. Finally, implications of the findings for practice, policy, and future research will be discussed.

Summary of Study

Little research has been conducted regarding the relationship between the demographic factors of adults and recommendations for sex education curriculum component/modules. This study explored the relationship demographic factors of adults and recommendations for sex education curriculum components/modules.

The results of the study revealed statistically significant associations through the chi-square analysis between gender and several components/modules. These components/modules include: condom use; female birth control; types of romantic and sexual relationships; sexual self-esteem and well-being regarding sex; appropriateness of grade in which individuals received sex education; and lesbian, gay, bisexual transgender, and queer (LGBTQ) topics. The chi-square test was approaching significance between gender and other safe sex practices as well as gender and pregnancy. The chi-square test was also approaching significance for the relationship between age and types of romantic and sexual relationships.
Discussion

The purpose of this study was to explore the relationship between demographic factors of adults and recommendations for sex education curriculum components/modules. The researcher compared sex education curriculum components/modules within the demographics of the participants, including gender, age, and ethnicity.

Statistically significant associations and trend level data were found between gender and component recommendations and trend level data was found between age and one component recommendation. When examining various sex education curriculum components/modules, ethnicity does not appear to play a significant role in that individual’s recommendations. As shown in this study, there were no statistically significant associations or trend level data for this variable.

When utilizing the ecological model to analyze the research findings, it is critical to be aware of the various social factors that may influence or affect an individual’s beliefs, values, attitudes, or opinions regarding sex education. As the ecological approach states, the sexual choices adolescents make are influenced by multiple levels of interrelationships (Salazar et al., 2009). Though the direct contact with peers, family, and educators (micro) may appear to be the only driving force behind adolescents’ sexual behaviors and choices, Salazar points out that cultural beliefs and values (macro) are just as much of an influence on adolescents’ decision-making.

This researcher found in the review of the literature studies regarding female birth control methods, (e.g., oral contraceptives, vaginal ring, or hormone injections), condom
use, other safe sex practices (e.g., withdrawal, masturbation, spermicide, or dental dam), pregnancy, and perceived appropriateness of timing of the sex education students received (Guttmacher, n.d.). Though this research study did not explicitly examine the relationship between gender and actual condom or contraceptive use, the literature suggests that adolescents who are provided with education on various types of contraceptives are more likely to use said contraceptives than those who do not receive the contraceptive education (Eisen, Zellman, & McAlister, 1990; Mauldon & Luker, 1996). This is especially true when students receive the education the year they become sexually active (Jones, Biddlecom, Herbert, & Mellor, 2011; Orr & Langefeld, 1993). By using the ecological perspective, which takes into account the external factors related to relationships and the internal ones including maturity and sexual drive, the timing of the education is very effective (Basen-Engquist et al., 2001; Salazar et al., 2009). This is consistent with the findings of this research study as all participants who recommended sex education in school reported the necessity for contraceptive education and interventions beginning in fifth or sixth grade.

While reviewing the literature on sex education, various studies were found regarding types of romantic and sexual relationships, sexual self-esteem and well-being regarding sex, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) topics (Adler-Baeder, Kerpelman, Schramm, Higginbotham, & Paulk, 2007; Blake et al., 2001; Gardner, 2001; Halpern-Meekin, 2012; Luker, 2006; McGarry, 2013; Sales, Milhausen, & DiClemente; 2006). These three topics, though each comprehensive in their own right, are interrelated as key components of sex education. Romantic and sexual relationships
are closely tied to feelings of self-worth, self-esteem, and well-being. When students are allowed to discuss issues such as gender or ethnicity as they relate to sex, students report feeling more accepted by and more connected to their peers (Adler-Baeder, Kerpelman, Schramm, Higginbotham, & Paulk, 2007; Gardner, 2001; Sales, Milhausen, & DiClemente, 2006). This is consistent in the data gathered for this research study as all participants who recommended sex education stated the need for discussion regarding sexual and romantic relationships.

In the context of LGBTQ topics, many studies focus solely on reducing sexually-risky behavior for those who identify within the LGBTQ community but do not incorporate more external or macro issues related to those behaviors (Blake et al., 2001). Further still, many teenagers do not receive gay-sensitive sex education, which leaves many LGBTQ individuals feeling isolated from their peers (McGarry, 2013). Integration of gay-sensitive material into sex education curriculum is vital for the sexual health and well-being of these youth. This research study supports this notion based on the responses received regarding the need to spend more time educating adolescents on LGBTQ topics.

This research study explored the relationship between various adult demographics and the sex education curriculum components/modules those individuals would recommend in an ideal sex education program. This researcher used the ecological theory to explain the associations between the demographics and sex education components/modules. However, as this research study found statistically significant
associations between gender and various sex education curriculum components/modules, another theory that might explain this relationship is feminist theory.

Although the literature reviewed in this study did not specifically discuss feminist theory, it is very applicable when exploring relationships around gender. As feminist theory explains, gender can be viewed as a social construct that sets specific expectations and standards on individuals based on their perceived “gender presentation” to others (Butler, 1988). This research study found a statistical significance between gender and the recommended length of time in which specific sex education components/modules should be taught. In other words, males recommended that certain sex education components/modules should be taught for much shorter periods of times while females recommended greater periods of time for those same components/modules. On average, males reported topics should be taught for less than eight weeks and females reported topics should be taught for more than eight weeks. Through the lens of feminist theory, one might argue that females feel the sense of responsibility when it comes to matters related to sex. They are responsible for chastity, purity (i.e., free of sexually-transmitted infections), and protection from pregnancy (Augustine & Hunter, 1999; Rury, 1987). Most research on teen pregnancy revolves around the female teen mother (Basen-Engquist et al., 2001; Cavazos-Rehg et al., 2012; DiClemente et al., 2004). Males and their roles in pregnancy are not the focus of these research studies, which systematically helps to reinforce the sexual responsibilities of teenage females.
Limitations

There are a number of limitations that are considered within this research study. One such limitation is the number of participants (N=30), which is small to conduct statistical analysis. A second limitation of this research study is the collection method. Potential participants on campus may have been dissuaded from completing a questionnaire from a stranger or may have been on a schedule that prevented them from taking the time out of their day to fill out a survey. Additionally, there may have been those who did not wish to participate due to the subject matter of the research study. Some participants may have felt the subject was inappropriate to discuss in public or had no opinion on the topic. The survey itself may have been flawed. The structure and content of the survey questions regarding sex education curriculum components/modules may have been too confusing for participants to understand. The survey should be reexamined and corrected so its questions appear more clearly stated and defined.

Finally, it is possible the researcher introduced bias during the design of the study, data collection phase, and analysis of the data. As the researcher was looking for recommendations regarding sex education curriculum components/modules, it is possible the researcher was looking for respondents who were interested in having more comprehensive sex education in schools. In order to further the research on this topic, a larger sample size is needed and adjustments to the survey tool should be considered to reduce the problems and/ bias that may have occurred with this research study. Additionally, qualitative studies would be useful in further understanding this topic in depth.
Implications for Social Work Practice and Policy

This study presents implications for social work practice and policy. Presently, only a small amount of research exists regarding the relationship between demographic factors of adults and ways in which those influence their recommendations for sex education curriculum/components. Results gathered from this research study suggest the justification for further research on this topic.

On the micro level, it would be ideal for individuals and families to be aware of all the different types of sex education curriculum components/modules and the ways in which their demographic factors affect their recommendations for such programs. It would also be important for individuals and families to seek out additional information and research regarding all the possible components/modules of various sex education curriculums. If the information that was presented in this study is utilized by individuals and families with children, then it would hopefully increase the advocacy for more specific sex education program models in schools.

On the mezzo level, the findings in this study can better educate and prepare social workers, educators, school administrators, and health professionals to meet the needs of adolescents in sex education programs. By knowing the ways in which demographic characteristics influence the preferences individuals have for sex education, components/modules, social workers, educators, administrators, and health care professionals can employ more beneficial and appropriate interventions for adolescents. For example, rather than simply teaching students about sexually-transmitted infections, it would be beneficial to also incorporate dialogue regarding the different types of
romantic and sexual relationships and the ways in which those definitions may be
different for males or females.

On the macro level, State and Federal policy on sex education could focus on
long-term interventions, preventions, and treatments of sexually based issues such as
sexually-transmitted infections, teen pregnancies, and sexual assaults. Continuous
reassessment of sex education curriculum components/modules by policy makers and
researchers would greatly benefit the sex education models taught to adolescents in the
United States. Other benefits include the implementation of the ecological perspective by
educators and social workers as they consider all the implications of the various sex
education components/modules taught to adolescents.

Whether it be on the micro, mezzo, or macro level, social workers have an ethical
responsibility to advocate for comprehensive sex education. Under the National
Association of Social Worker’s Code of Ethics (2008) social workers are trained to
incorporate the ethical principles set forth by the profession into the work they do in the
community. Service, social justice, dignity and worth of the person, and importance of
human relationships are all values in which social workers need to apply to the advocacy
and advancement of sex education reform in the United States.

Further research is necessary to validate the need to increase the content and
amount of time spent teaching sex education rather than relying on currently employed
models. Additionally, future research studies may need to focus on educational policy
changes and implementation methods that are most useful for school-based sex education
programs.
Recommendations

The purpose of this study was to explore the relationship between demographic factors of adults and the recommendations for sex education curriculum components/modules. The following section is a list of recommendations developed for social workers, educators, education administrators, and health care providers for future sex education curriculums:

• Current sex education programs vary depending on the state or region in which the education is taught. Policy reforms could be introduced to create equal access to comprehensive sex education for students regardless of the state or region in which they reside. Uniformity in sex education is important as it provides the opportunity for all adolescents to access important information related to their sexual health, self-esteem, and well-being. It also allows adolescents to become more informed of their options and the ways in which they can realistically protect themselves from sexually-transmitted infections, pregnancies, and unhealthy relationships (Constantine, Jerman, & Huang, 2007; Dallard, 2001; Halpern-Meekin, 2012; Irvine, 2002; Kirby, 2007; Landry, Darroch, Singh, & Higgins, 2003; Santelli et al., 2006).

• In order to produce more consistent results from sex education curriculums, there must be a standard training program in place for those who teach sex education. Educators, social workers, and health professionals who educate adolescents about sex could receive regular trainings to ensure they are consistently meeting sufficient and regulated standards set forth by local, state,
and federal agencies (Berne & Huberman, 1999; Hoppe et al., 2004; Landry, Darroch, Singh, & Higgins, 2003; Sales, Milhausen, & DiClemente, 2006).

• As technology becomes more advanced, access to information about sex and related topics becomes increasingly more accessible and readily available to adolescents. Therefore, it is crucial that educators, social workers, and health care professionals begin integrating dialogue related to virtual sex practices into their discussions with adolescents. These discussions help adolescents ascertain the differences between the facts about sex and sexuality and misguided or false information provided via the Internet (Alvarez, 2012; Bergdall et al., 2012; Landry, Gonzales, Wood, & Vyas, 2013; Sabina, Wolak, & Finkelhor, 2008; Wolak, Mitchell, & Finkelhor, 2007).

• The research of this study highlights the need for further study into various aspects of sex education and program components/modules. An area of focus could examine the various components/modules adolescents would want within their own sex education curriculum that would help them to better their understanding about human sexuality. Another area of focus could concentrate on the ways in which certain components/modules such as interpersonal relationships and virtual sex practices influence the sexual behaviors of adolescents. A third area of focus could include the various attitudes and perceptions adolescents have about sex and sexuality based on demographic factors such as gender, race/ethnicity, religion, geographic location, income level, and sexual orientation (Adler-Baeder, Kerpelman, Schramm,
Higginbotham, & Paulk, 2007; Blake et al., 2001; Hoppe et al., 2004; Kraft, Kulkarni, Hsia, Jamieson, & Warner, 2012; McGarry, 2013; Rury, 1987; Salazar et al., 2009; Whitehead, Wilcox, & Rostosky, 2001).

**Conclusion**

The primary purpose of this study was to examine the relationship between adult demographic characteristics and the ways in which they influenced the individual’s recommendations for sex education curriculum components/modules. The secondary purpose was to increase the amount of research that exists on this particular topic, as there is currently a minimal amount of research. The findings suggest that additional research is necessary to ensure a more indicative understanding and application of this topic. Future application of research findings may increase the types of comprehensive sex education curriculum components/modules incorporated into school sex education programs. The materials presented may be better suited to adolescents through the creation of more tailored and enhanced components/modules based on demographic factors such as gender or ethnicity. This study could be duplicated in order to obtain the larger sample size required to validate any findings for this topic. Future quantitative and qualitative research studies may enhance and add to the current research on sex education.
APPENDIX A

Consent to Participate in Research

This research survey is being conducted by Crystal Fickey, a Masters of Social Work student from the Division of Social Work at California State University, Sacramento. The research being conducted is designed to explore the curriculum recommendations adults have for future sex education programs.

Procedures:
Should you decide to continue after reviewing this form, your consent will be implied by the completion of the attached survey. The survey will consist of multiple choice and liker-scale questions. Some questions will allow you to provide more than one answer. These questions will indicate that you may check all that apply. We ask that you try to answer all questions. However, if there are any questions you would prefer to skip, simply leave the answer blank. The survey should take no more than ten minutes to complete. Once you complete your survey, and if you still chose to submit it, you will place the survey in a box provided by the researcher. You may then select a condom or some candy as an honorarium for participating.

By completing this survey, you are agreeing to participate in the study. You must be at least 18 years old to participate. *If you are not 18 or older, please inform the researcher and do not complete the survey.*

Risks:
There are no foreseeable risks associated with your participation in this study. However, should the topic of sex education prove unsettled or otherwise result in any emotional discomfort, you may seek free counseling services at the Counseling and Psychological Services center at California State University, Sacramento. Staff at the center may be reached at (916) 278-6461.

Benefits:
The findings in this study may increase knowledge of topics adults would recommend for future sex education programs. It may offer you, as a participant, an opportunity to consider your own knowledge regarding sex education. The knowledge gained from this survey might also be used in assessing better future sex education curriculum topics on the state and national level.

Confidentiality:
Your responses are anonymous; you should not include any identifying information on this survey. Every effort will be made to protect your anonymity and confidentiality. Completed surveys will remain in a box provided by the researcher and kept in her home. The researcher will be the only person to have access to your responses. Upon the completion of the study, survey responses will be destroyed by the researcher.
Compensation:
Participants who chose to complete the survey will receive either a condom or some candy as an honorarium. There are no fiscal benefits associated with completing this research.

Rights to Withdraw:
As previously stated, you have the right to withdraw from this research study at any point prior to your submission of the survey. Once the survey has been submitted, however, the researcher will be unable to remove your survey or any particular response from the box.

Should you have any questions, please contact the researcher:

Name: Crystal Fickey
Title: MSW II Student
Dept: Social Work
California State University, Sacramento
Email: cf896@saclink.csus.edu

For further information, you may also contact the researcher’s thesis advisor:

Name: Maria C. Dinis, Ph.D., MSW
Title: Chair, CSUS Committee for the Protection of Human Subjects
Dept: Social Work
California State University, Sacramento
Phone: (916) 278-7161
Email: dinis@csus.edu

This research has been reviewed by the Institutional Review Board for the Protection of Human Subjects (IRB). If you have any questions about your rights as a participant, or if you feel that your rights have been violated, please contact the California State University, Sacramento IRB at (916) 278-5674

Please keep these sheets for your reference.
APPENDIX B

Survey Instrument

1. Gender:  □ Male  □ Female  □ Other

2. Age:  □ 18-24  □ 25-29  □ 30-34  □ 35+

3. Race/Ethnicity (Please check all that apply):
   □ African American/Black  □ Asian/Asian American  □ Caucasian/White
   □ Latino  □ Native American/Alaskan Native  □ Other (please describe): __________________________________________________________________________

4. Did you receive sex education while in elementary, middle, or high school through health or another class?
   □ Yes  □ No

   *If yes, please go to question 5. If no, skip to question 7.*

5. When do you remember taking sex education? (Please check all that apply)
   □ 5th Grade  □ 9th Grade
   □ 6th Grade  □ 10th Grade
   □ 7th Grade  □ 11th Grade
   □ 8th Grade  □ 12th Grade

6. I feel the grade in which I received sex education was:
   □ 1- A couple of years too early
   □ 2- One year too early
   □ 3- Appropriate timing
   □ 4- A year too late
   □ 5- A couple of years too late.
   □ 6- Other (Please Describe): __________________________________________

7. Do you think sex education should be taught in school?  □ Yes  □ No

   *If yes, please go to question 8. If no, skip to question 9.*
8. If I could create the ideal weekly one-hour sex education curriculum for 15 weeks, I would include information on the following topics for at least (circle the appropriate number of weeks you would discuss topic):

<table>
<thead>
<tr>
<th>Topic</th>
<th>Weeks Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male reproduction system</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Female reproduction system</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Condom use</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Female birth control, such as: pills, IUD, vaginal ring, hormone injections</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Other safe sex practices, such as: spermicide, dental dam, female condom, sponges, withdrawal, and masturbation</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Information on sexually-transmitted infections, such as: HIV/AIDS, Chlamydia, Gonorrhea, Genital Herpes, Syphilis, Viral Hepatitis, Bacterial Vaginosis, Human Papillomavirus, Pelvic Inflammatory Disease, Pubic Lice</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Abstinence (as a safe sex option)</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Abstinence-Only education (no other sex education)</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Virtual sex, such as: texting (or sexting), camera phone pictures and videos, pornography</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Types of romantic and sexual relationships</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>Sexual self-esteem and well-being regarding sex</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
<tr>
<td>LGBTQ (Lesbian, gay, Bisexual, Transgender, Queer) topics</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</td>
<td></td>
</tr>
</tbody>
</table>
9. Why or why not should sex education be taught? Please describe.
APPENDIX C

Purpose of Study

“Hello, my name is Crystal Fickey. I am conducting a study on sex education. I am seeking curriculum recommendations on what topics should be included when teaching sex education to children/teenagers in school. Do you have a few minutes to complete this survey?”

If the respondent says “Yes” then I will pass out the survey materials.

If the survey respondent says “No” or simply walks away, I will say, “Thank you” and move on to another person passing by and start all over again with my script.
References


