Examining sexual consent education for first year college students: A program evaluation

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A Doctoral Project Submitted in Partial Fulfillment of
the Requirements of the Degree of Doctor of Psychology
in the Department of Psychology at Pace University

New York
2021

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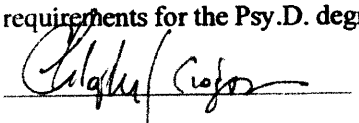
I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.



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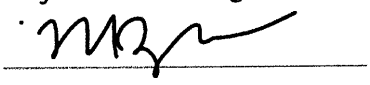

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7/19/21

Date

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

I would like to first dedicate this doctoral project to the late Dean Marijo Russell O'Grady. Dean O'Grady fought a valiant battle against cancer and passed away in August 2020. Prior to this, she had agreed to be a third reader for this doctoral project, and her support and enthusiasm for it made this possible. Dean O'Grady was known for her warm and energetic spirit and passion for the student body at Pace. She was dedicated to ensuring the safety and wellbeing of students, particularly related to sexual health by creating task forces, discussion panels, and working closely with The Office Sexual and Interpersonal Wellness. Thank you, Dean O'Grady, for approving and believing in my work from the time I was an undergraduate and for your unwavering advocacy for the students at Pace. You are deeply missed and appreciated.

Next, I would like to express my most sincere gratitude to my doctoral project advisor, Dr. Christopher Godfrey and consultant, Dr. Michele Zaccario. Dr. Godfrey, also known affectionately as "a benevolent dictator," has been one of the most support mentors I have experienced throughout both my undergraduate as well as graduate careers. You have helped me refine my skills and hone in on my research interests. I thank you for your candidness, your patience, and knowledge. Dr. Zaccario, it is hard to believe that it has been nearly ten years since we met, and you taught me as a freshman. It is remarkable to complete this doctoral project focused on first year students at Pace, as it truly feels like this is where my journey began. Thank you for your kindness, your guidance and mentorship, and for believing in me. Thank you both for being along with me through the hurdles and excitement of finishing my degree.

I feel humbled and honored to be in this position where I can pursue a career, I am passionate about while helping others. None of this would be possible without the patients who put their trust in me during their most vulnerable moments, and therefore I am especially thankful for these individuals.

Last, I would like to thank my family and friends for being my biggest cheerleaders for these past five years and beyond. First, to the friends I have made in this program, I love you and I cannot imagine this experience without you. It has been incredible to see each of us grow into the clinicians we are today. Thank you for putting up with my quirks and always sticking by my side. To my parents, thank you for instilling the value of education in me. Without you and your hard work, I would not have been able to achieve this milestone. It is a privilege to be the first doctor in the family, and I continue to make you proud! Finally, I want to thank my husband, Richard Williams. You have believed in me since we were in the eleventh grade. No dream of mine is too big for you. Thank you for waiting up for me to get home from class, for being my personal editor and for never forgetting to remind me how proud you are of me and that I am "blessed and highly favored". I am endlessly grateful for the sacrifices you have made for me to achieve this and for the love you show me every day.

ABSTRACT

Our country spends tens of millions of dollars annually on sex education but there are still several issues related to sexual behavior that arise including, an increase in transmitted infections in young adults, rates of sexual assault and varied knowledge in sexual consent, which ultimately impacts the wellbeing of our youth (Boonstra, 2010; Williams and Jensen, 2015; RAIIN, 2014; Muehlenhard et al., 2016). Additionally, government initiatives have recognized sexual assault as an emerging issue, possibly since 13-30% of female college students have experienced sexual assault (Muehlenhard et al., 2016; https://www.healthypeople.gov/). Understanding how sexual consent plays a role in these problems is crucial (Williams and Jensen, 2015). This study evaluated a current sexual assault education and prevention program at a local private, urban university. Specifically, the aim of this study was to understand how health-based interventions influence first-year college students' attitudes, beliefs, and behaviors around sexual consent using a post-posttest survey design. Institutional Review Board approval was obtained from the appropriate university board and data collection took place until March 2020. results from this study show an increase in directive communication styles around sexual consent. Based on these results, recommendations are proposed for universities to adopt health-based interventions as well as for more research to be completed in this area to develop evidence-based interventions that address sexual health and well-being. This novel study provides insights for individuals who are involved with student life and campus mental health initiatives, as well as university administration, so that they may create and disseminate health interventions to their student body.

Keywords: sexual health, adolescents, sexual consent, sex education

Chapter I.

Introduction

Epidemiology of problem:

Sexual violence and sexual health are important public health issues. According to the Rape, Abuse, and Incest National Network (RAINN), every two minutes an American is sexually assaulted (2014). This adds up to about 237,868 victims of sexual assault every year (RAINN, 2014). Overall, young females and transgender individuals are more likely to be the victims of sexual assault or rape (Criminal Victimization, 2003 and Muehlenhard et al., 2016). Eighty percent of victims are under the age of 30 (RAINN, 2014). Healthy People 2020 has also recognized sexual assault as an emerging injury and violence issue in the United States (ODPHO, 2020). More specifically, college age women (18-24 years old) are three to four times more likely to experience sexual assault when compared to all women (RAIIN, 2021). In fact, between 13-30% of female college students have experienced some form of sexual assault (Muehlenhard et al., 2016). Given these data, it is more important than ever to understand how college students are navigating sexual behaviors.

Research indicates that there is currently limited understanding about how college age individuals navigate sexual behaviors (Jozkowski et al., 2014), however, The World Health Organization has declared that addressing the sexual and reproductive needs of adolescents is a crucial element in promoting the sexual health and safety of all adolescents (Fantasia, 2011). This is important because research indicates that there is a direct link to lack of use of consent and sexual assault and alternatively, the utilization of consent which promotes sexual health and well-being (Warren, Swan, and Allen, 2014 and Grose, Grabe, & Kohfeldt, 2014). Although

there is some research to date on adolescent sexual behavior, understanding their knowledge and behaviors around sexual consent is still not well understood. Late adolescents are a part of the "college-age population," and are of particular interest in this area of research due to data suggesting that first year college students are at the highest risk for experiencing sexual assault (Fantasia, 2011 and Cranney, 2014). Consent is conceptualized as both a mental and physical act that one decides about (Muehlenhard et al., 2016). For a variety of reasons, such as social perceptions, intoxication, lack of knowledge, impulsive behavior and more, college aged students may not consistently obtain sexual consent. This observed pattern is linked to risky sexual decision making in late adolescents (Fantasia, 2011).

Some new research aims to try to understand the college-age population perception of risky behavior. For example, Fantasia (2011) studied a group of participants and found that decision making around sex initiation indicated that adolescents reflected on a great sense of "feeling like they should be having sex" and decisions to initiate sexual activity are made quickly without much deliberation (Fantasia, 2011). This helps us begin to understand that when adolescents are engaging in sex, they may be doing so with little thought, and possibly little consent. We also can see how sexual behavior, particularly during adolescence, can be uninformed and may be is centered around social rules such as gendered norms which influence sexual behavior and consenting (Muehlenhard et al., 2016; Jozkowski, Marcantonio, & Hunt, 2017; Marcantonio et al., 2018). There is also data to suggests that young people may not have a full understanding of the risks and rewards associated with sexual activity (Muehlenhard et al., 2016). In fact, one study showed that as involvement in risky sexual behavior increased, college students' estimates, or perceptions of risk decreased Fantasia, 2011). This suggests that the participants appeared to not recognize that their behavior was elevating their risk (Fantasia, 2011). This summarized

research begins to show patterns in adolescent sexual behavior and risk taking however, more information on adolescent decision making and use of consent is needed.

What is Consent?

it is crucial to first understand the concept of sexual consent. For the purposes of this study, consent is a concept defined as "given when a person freely agrees to do something". In relation to sex, consent should be mandatory every time. Specifically, consent must be freely given, informed, specific, reversible, enthusiastic, and continuous (RAIIN, 2014). Consent may also be conceptualized as both a mental and physical act (Muehlenhard et al., 2016). Although this definition of consent is precise, issues and confusion arise since laws on what qualifies as consent can vary in this country by state and situation (RAIIN, 2020). Due to the inconsistencies that can arise around the definition of sexual consent, a more global concept around consent is necessary. Research has already set out to identify a difference between not wanting to have sex and not consenting to sex (Muehlenhard et al., 2016). Often, individuals find that they will consent to sex, even within an established relationship, since there is a sense of "obligation" or need to engage to maintain something (Muehlenhard et al., 2016). Separate from this is when sex takes place and consent has not be explicitly given. As one study wrote: "Rape is about the absence of consent, not the absence of desire" (Muehlenhard et al., 2016). For many people, determining the distinction between not wanting to have sex and not consenting to sex is a challenge, particularly college students. For this reason, some researchers have begun to develop measures to examine how college students navigate sexual consent (Jozkowski & Peterson, 2014). By quantifying students' behavior, researchers can better understand the trends in this public health issue, and where interventions may be implemented.

Statement of purpose

The current study aimed to examine the effectiveness of a health-based intervention for first year college students at an urban private university. Specifically, this study aimed to examine the intervention's effectiveness at changing students' attitudes, beliefs, and behaviors regarding sexual consent. This study is the first known of its kind, and while the university has collected data on its students' substance use, it has no collected data on other forms of risk behavior. Lack of data on SAE presents a challenge to the university's efforts to create a healthier and safer student body. This study sought to provide insight on the effectiveness of SAE programming in service of developing understanding and improving health-based interventions. This study also sought to provide a foundation for future research to continue program evaluation on this important topic.

The sample observed in this study receive this intervention as a part of their Introduction to University Life curriculum. This course was developed to assist students in exploring the unique aspects of university life through self-exploration. In addition to this, the university has implemented violence prevention initiatives, trainings, and events, which this intervention falls under. This intervention is introduced at this time specifically because freshman female students are at highest risk for sexual assault and research indicates that the first semester of college is when students are most likely to engage in heavy drinking and sexual activity (Testa and Hone, 2019). These findings also stress the importance of offering sexual assault prevention interventions and programming.

Research Questions

The study proposes that students' exposure to the sexual consent education intervention will lead to positive attitudes about sexual consent. This will lead to a direct effect and an increase in

intention to engage in consenting behavior as well as an increase in knowledge about sexual consent.

Chapter II.

Literature Review

Late Adolescence - A Developmental Perspective

In today's world the term "adolescence" appears to be evolving. This period between late childhood and early adulthood, has recently been categorized as a second vital developmental period (Steinberg, 2015). While some studies define "late adolescence" as ages 18 to 23 years old, others suggest its timeframe to be about 17 to 24 years old (Cabria et al, 2017; Steinberg, 2015). It has been found to be such a critical period since major portions of the brain are still developing during this time. Namely, the portions of the brain that impact decision making, and the reward center of the brain (Steinberg, 2015). Specifically, the brain systems that are thought to be more impacted during this cognitive stage of development are the *fronto-striatal system*, a collection of neurons that works to assess benefit and risk associated with a certain stimulus, and a separate prefrontal system that works to exert control of engagement risky behavior (Kim-Spoon et al., 2016). Due to the plasticity of the adolescent brain, development of these systems provides one final opportunity to help individuals establish neuronal connections that will enable them to be better equipped to make thoughtful decisions, weigh the pros and cons, and delay gratification to keep healthy and safe (Steinberg, 2015). Compared to adults, adolescents demonstrate greater reward sensitivity and heightened risk-taking behavior (Cabria et al, 2017). It is quite developmentally typical for students to be experimenting socially, particularly with their sexuality; however, this is a developmental period where they are also at an increased risk for poor judgment and making decisions based on social norms (Muehlenhard et al., 2016). Much of the literature in this area connects the adolescent brain, decision making and risky

behavior to substance use, however, it is clear that risky behavior extends to other behaviors, such as sexual situations as well.

Given the findings that adolescent brains both continue to make new connections and that it is a heightened time of risk taking due to the state of the pre-frontal cortex, developmentally appropriate sex education is a critical element in promoting wellbeing (Fantasia, 2011). Aside from adolescents, consent education can be approached from a developmental perspective for all age groups and adapted so that it can be incorporated earlier in a students' education. The idea of delivering sexual health information throughout a student's development is not only recommended by health professionals, but also supported throughout the literature that recognizing youth sexuality, discussing sexual orientation, and building skills to promote sexual health is suggested as a part of this education (Weaver, Smith, and Kippax, 2005 and Canan and Jozkowski, 2017). Canan and Jozkowski (2017) asked about sexual education and participants indicated that as grade level increased, so should the number of topics that are taught. For example, this may include discussing topics such as sharing and safe/appropriate touching with young children, and then moving onto healthy communication, sex positivity and sexual consent with adolescents. Given the research that suggests sex education is best delivered on a developmentally appropriate timeline, then perhaps extending sex education and intervention programs to meet the unique social and sexual situations encountered during college would be beneficial for late adolescents. Given the neurocognitive findings regarding adolescents' brain development, risk taking behaviors, and the delivery of sex education, a developmental prospective is best suited for this topic of consent education.

A Multifaceted Problem

Lack of knowledge

One of the major issues that comes into play when considering consent, is the overall lack consistency in this knowledge, particularly in what students are being taught. There is no current uniformity to what adolescents are taught in health education across the country. According to the Center of Disease Control (CDC) and Planned Parenthood, less than half of high schools, and only a fifth of middle schools teach all 16 topics recommended by the CDC. Some of these topics include basic information on human immunodeficiency virus and other sexually transmitted infections, as well as methods of contraception, family, and peer influence on risky sexual behavior, how to sustain healthy relationships and critical communication and decision-making skills (CDC, 2020). This means that potentially, over half of the county's population of adolescents are entering college without any skills needed to navigate communication and decision making in sexual relationships and the other half's knowledge ranges from minimal to comprehensive.

When examined further, college age students in one study reflected that although they received school-based sexual education, it lacked information about safe situations and communication with a partner (Fantasia, 2011). Due to this lack of consistency, consent is a wide-ranging concept among college age students (Jozkowski et al., 2014). This makes it challenging to understand consent behavior and how to address it. Additionally. there is little recorded information regarding how college students consent to sex and their understanding of it (Jozkowski et al., 2014).

Due to largely inadequate sex education in this country, many young people may be unaware of exactly what they are consenting to when consent is expressed. There is a chance that

they are mis- or uninformed about the real risks and rewards to engaging in sexual activity, and their consent may be compromised, in turn (Muehlenhard et al., 2016). The research highlights the pattern that college students have more unfettered choice but not a full understanding of the consequences associated with those choices (Fantasia, 2011). Developmentally, college students are presented with a new sense of independence, and this often creates a conundrum. In many cases, these students have not been appropriately taught how to make decisions or navigate potentially risky situations. Another study reported that adolescent women indicated that their perception is that intercourse is "expected" from their older partners as a part of a relationship; however, they also noted that they never learned how to have an open discussion about sex (Fantasia, 2011). By not preparing adolescents for these types of discussions around consent, we are placing them at risk.

Negative attitudes

Beyond the lack of consistency around how adolescents learn about and use sexual consent, there is a hurdle of negative attitudes or views of the implementation of consent in real life. Research suggests that individuals' lack of understanding is not the only issue that comes with consent, but also that perpetrators of sexual assault may be more likely to disregard another's rights and boundaries (Warren, Swan, and Allen, 2014). Further, selective ignorance of non-consent surely makes up for a portion of acquaintance rape (Jozkowski, Peterson, Sanders, Dennis, & Reece, 2014). This means that we need to not only address young adult's understanding of what consent is, but also work to change their attitudes around it. Sex is also inherently tied to gender roles, such as women being submissive, and males asserting their dominance. Due to this, consent is a topic in which theses gendered norms are reflected and students have little experience in challenging these societal rules (Muehlenhard et al., 2016). As

it stands, much of sex education focuses abstinence only programming as a means of protection when the focus should be on how to promote healthy and consensual behaviors (Weaver, Smith, and Kippax, 2005).

Ambiguity

Another concept that some research has aimed to illuminate is exactly how consent is thought of and navigated by individuals. Consent between college-aged sexual partners appears to be widely navigated through non-verbal cues, potentially leading to ambiguous and confusing situations (Jozkowski & Peterson, 2013). Ambivalence is a concept that can be closely related to ambiguous situations. Ambivalence, which can be defined as having mixed thoughts or feelings towards something, can play a role in how we make decisions related to sex. (Muehlenhard et al., 2016). There are some factors to consider about ambivalence and sexual consent. First, an individual can have ambivalent feelings about actually engaging in a particularly sexual act, or about sex in general (Muehlenhard et al., 2016). Knowing this, we can make that connection that ambivalence plays some role in sexual consent due to the fact that giving explicit consent requires an ability to have some internal reflection and offer distinct permission, which inherently may be a challenge if the individual is somewhat unsure (Muehlenhard et al., 2016). Another factor to consider is college students' consumption of alcohol and engagement in "party culture". Often times, alcohol and drugs are involved in scenarios of sexual assault, particularly among the college age population. Alcohol and other substances also play a role in risk taking behavior, and in extremes, can incapacitate someone making them unable to consent (Muehlenhard et al., 2016). For the reasons laid out, it has become increasingly important to think about how adolescents can begin to access sexual consent knowledge in an effective way.

The Public/Social View

Beyond college students' attitudes, beliefs, and behavior around sexual consent, the public views around sexual assault, sex education, and consent are important to take into consideration given their implications. According to research, sexual consent in rooted in gender norms, meaning societal ideas may put pressures or expectations on how sexual relationships are navigated (Jozkowski et al., 2017). In reaction to this, the literature has pointed out a need for an effort to be made to increase positive sexual communication through the implementation of programs that address this. (Marcantonio et al., 2018).

The message around consent has also changed across time from "no means no" to "yes means yes," as initiated by California's 2014 legislation that requires affirmative consent (DeMatteo et al., 2015) and followed by young adults' advocacy in sexual violence prevention programming utilizing slogans such as "consent is sexy" (Beres, 2014). This is a beneficial change to the societal view of sexual consent because it helps to impart change around the behavior. Part of the reason for doing this is if someone is unable to say "no" their silence is not confused for consent (Muehlenhard et al., 2016). By taking the approach of "yes means yes", it highlights the importance of active and affirmative consent (Muehlenhard et al., 2016). Research in this area has consistently shown students' stand opposite to the definition of consent being adopted by their schools (Muehlenhard et al., 2016). Given the nature of college students' decision-making processes and tendency towards hook up culture, students are sure that they do not want a school policy to dictate their behavior. Although students did not want to be bound by a policy, they do believe that education around sexual consent would promote communication between sexual partners and could be a useful tool rather than a rule set out by the institution (Muehlenhard et al., 2016). While some views of sexual consent remain narrow, we do see

others transforming in a social context with movements such as #MeToo. highlighting that there is room for change in society's view of sexual consent.

The Law and Policies

If we consider the research that suggests that college students are against having policies in place that regulate their sexuality, we begin to uncover some of the basic issues around consent and sexual assault. Part of the problem with policies and administrative changes is that they are not intended for consumers; rather, they are done legislatively without much recognition of best practices in sexual assault prevention and reporting (DeMatteo et al., 2015). Nationally, post-secondary institutions have been somewhat forced into implementing policies in reaction to the 2014 Obama Administration's change in guidelines for colleges and universities to fully investigate sexual assault complaints and in reaction to the "Its on Us" campaign which highlights the prevalence of sexual assault on college campuses (Muehlenhard et al., 2016 and DeMatteo et al., 2015). This follows that sexual violence has been identified as a form of discrimination that is prohibited by Title IX. Therefore, when acts of violence occur in the context of a college campus, schools are legally obligated to investigate (Muehlenhard et al., 2016). Due to this, some schools have taken on the responsibility of written definition of consent as a part of their policies to inform their student body in an effort to prevent sexual assault on campus (Muehlenhard et al., 2016). Change in law means a change in policy for universities. As schools began adapting policies around sexual assault, the need to create definitions and guidelines for consent became apparent. From the perspective of university policy, consent in the is viewed solely as *explicit* consent which, is defined as overt and outwardly expressed, rather than the *implicit* concept which refers to someone's internal state, or their internal willingness (Muehlenhard et al., 2016). Of note, given the context and location of this study, New York and

California have legislated that universities must abide by an affirmative consent policy. This means that a lack of resistance before or during sexual activity does not qualify as consent—consent must be actively communicated (Muehlenhard et al., 2016). Universities and colleges increasingly rely on policy, establishing campus-wide rules for behavior, to address students' interpersonal interactions, including sexual consent situations.

Primary and secondary schools face a variety of challenges when it comes to disseminating sexual health education. Namely, two of the major issues that arise are funding and curriculum. First, primary and secondary schools in the US must reapply for funding of sexual health education programs annually (Canan and Jozkowski, 2017). This limits the access that schools have for adequate funding, a longstanding issue schools in this country have faced when supporting comprehensive sex education. It was not until 2009 that any federal funding was made available for sexual health education, and quickly thereafter, in 2011, it was significantly cut (Canan and Jozkowski, 2017). Sexual health education has also always been a target for debate in the United States, due to our political system being rooted in religious and moralist beliefs. Some of the sex education curriculum in the is particularly outdated in that it only allows negative views of same sex relationships be taught (Canan and Jozkowski, 2017). Further, states do not require information to be medically correct. This is in stark contrast to similarly developed nations across the European Union states where it is reported that sex education must be "holistic", "honest", and comprehensively teach both the physiological aspects of sexuality as well as the relational ones (Canan and Jozkowski, 2017). Abstinence only programs that are still being taught in the United States, are not only dated, but also harmful (Constantine, 2008). Research suggests that in fact "liberal policies" around teaching sexual health do not "promote" sexual activity, but rather enable students to develop health sustaining

behaviors (Weaver, Smith, and Kippax, 2005). By giving youth accurate information about their sexual health, we enable them to make better, safer decisions rather than dampen the conversation around it.

Primary/Secondary Sexual Health Education Interventions

Currently, the way sex education is largely viewed in this country is as a means of prevention—the prevention of youth engaging in sex in all forms (Williams and Jensen, 2015). Although this is an unrealistic goal, the idea of using education as a means of prevention, specifically preventing sexual assault, could be a useful idea. Currently, sex education and sexual violence prevention are taught as two separate ideas (Cameron-Lewis & Allen, 2013). The reality is that these two things are not mutually exclusive. By keeping them separate rather than integrating them, we are not giving adolescents an opportunity to think about consent in terms of the ways sex can be both pleasurable and dangerous (Cameron-Lewis & Allen, 2013).

The evidence presented about our limited sexual health education and glaring statistics about adolescent sexual risk-taking behavior prove that the current approach is not meeting the needs of our young people. This country spends tens of millions of dollars annually on sex education but there are still several issues related to sexual behavior that arise including, an increase in transmitted infections in young adults, rates of sexual assault and varied knowledge in sexual consent, which ultimately impacts the wellbeing of our youth (Boonstra, 2010; Williams and Jensen, 2015; RAIIN, 2014; Muehlenhard et al., 2016). Beyond this, the curriculums across the country are not being utilized as an intervention tool. Decisions about what will be included in the sex education curriculum is mandated at the state level. After this, local school boards are able to decide what can be expanded on, although they cannot violate the regulations of what the state has set out (Williams and Jensen, 2015). In addition to this, in 2005, only nineteen states

mandated sex education be taught in school all together (Weaver, Smith, and Kippax). Unfortunately, not much has changed since then, and the sex education that students continue to receive is fragmented and incomplete (Constantine, 2008).

The CDC recommends that the instructors for sexual health and wellness courses be "well-trained" and "highly-qualified" (CDC, 2020), creating an issue when instructors who do not fit that criterion are asked to teach these courses. In schools, the definition of "sex or health educator" is an individual who is simply asked to teach on human sexuality (Williams and Jensen, 2015). However, this is only one part of their job, and teaching experience (Williams and Jensen, 2015). Often, the level of training they receive varies, with some receiving little-to-no formal training in sex education instruction (Williams and Jensen, 2015). If the individuals who are responsible for providing comprehensive sex education to our youth are inadequately trained and prepared, then there is certainly going to be gaps in adolescents' knowledge (Williams and Jensen, 2015). Sex educators' experiences and choices play a role in the quality of sex education programs, and by extension, in students' sexual-health outcomes (Williams and Jensen, 2015). Overall, we are missing a huge opportunity to provide interventions to our youth that could provide them with lifelong knowledge to change their attitudes, beliefs, and behavior around sexual consent and other areas of sexual health.

Schools are an optimal space to teach students about sexual wellness (Weaver, Smith, and Kippax, 2005). Research shows the benefits of sex education. These types of intervention programs are linked to sexual empowerment in youth (Grose, Grabe, & Kohfeldt, 2014). Health-based interventions that promote positive ideas about sexuality are seen to have great benefits throughout the literature. Sex education promotes progressive ideas about male and female roles, which is shown to be an important piece of consenting behavior, as well as promotes sexual

health and resource knowledge (Jozkowski, Marcantonio, & Hunt, 2017 and Grose, Grabe, & Kohfeldt, 2014). As noted, the United States differs from other developed nations not only in what is taught to their youth, but also their health outcomes. In countries such as the Netherlands, France, and Australia, comprehensive sex education focuses on recognizing youth sexuality, discussing sexual orientation, and building skills to promote sexual health (Weaver, Smith, and Kippax, 2005). In these countries, sexual health is introduced in primary school, whereas in the United States, it is typically first introduced in secondary school, a time when adolescents have already begun to experiment with their sexuality. More attention should be given to the gender differences that are present in how consent is approached when educating our youth (Jozkowski, Peterson, Sanders, Dennis, & Reece, 2014). Current trends in the literature leads us to see that educating not only adolescents in primary and secondary school, but also college students on sexual communication will likely prove beneficial for their relationships and enjoyment sexual encounters (Jozkowski, Peterson, Sanders, Dennis, & Reece, 2014). Education is a primary way to access youth and provide them with information that will make real difference in their health outcomes. Research highlights the success of health-based interventions used throughout other developed nations and suggests that it is time we start implementing some of these more comprehensive interventions throughout our education system (Darabi et al., 2017 and Weaver, Smith, and Kippax, 2005).

Health Communication Interventions

The Theory of Planned Behavior model is a cognitive based model that sets out to examine the intention to change a certain behavior (Ajzen, 1991). This research model considers individuals' attitudes, beliefs/norms, and perceived control in certain situations, particularly social ones. This model aims to predict an individual's intention to behave in a certain way given

a particular context or time and place. Intention is the key portion of this model in that behavioral intent is influenced by a person's beliefs, perceived control and attitudes about the behavior being observed (Ajzen, 1991). The theory of planned behavior has been used extensively in the development of behavioral interventions for sexuality and health. For example, a study that examined masculine norms followed the theory for planned behavior in asking men their intention to obtain consent (Hermann et al., 2018). Another study that set out to examine an educational intervention to reduce risky sexual behavior in an adolescent female Iranian population followed this model (Darabi et al., 2017). This study showed changes in attitudes and subjective norms as well as behavioral intention when compared to a control group who did not receive the same educational intervention (Durabi et al, 2017). These examples showcased the usefulness of this theory when examining sexual behavior as well as the attitudes and norms/beliefs that play a large role in individuals' intention to behave a certain way.

Gaps in the Current Literature

The literature outlined here has shown that there is a need to better understand how late adolescents understand and use sexual consent as well as the contexts in which consent is taught in sex education programs in secondary education, colleges, and universities This is of particular importance given that reports on the epidemiology of sexual violence have indicated sexual violence as an epidemic issue and that we must immediately consider the health outcomes for youth (Williams and Jensen, 2015; RAINN). Researchers have also indicated that has also indicated that greater focus needs to be placed on the differences in consenting behaviors between various gender identities, sexual orientations, relationship statuses, cultures, and religions (Jozkowski & Peterson, 2014). As the expectation both legally and socially increases for colleges to manage issues that arise on campus, some such as Canan and Jozkowski,

recommend that policy and programming be adapted at the collegiate level to incorporate sexual education health-based interventions (2017). Research notes that comprehensive sex education that places attention on sexual communication is related to better health outcomes and more enjoyable sexual encounters (Jozkowski, Peterson, Sanders, Dennis, & Reece, 2014).

Sexual Consent/Sexual Assault Education Intervention

In 2014, President Obama employed the "It's On Us" campaign to raise awareness about sexual assault and bystander issues (Muehlenhard et al., 2016). Since then, Pace University too has taken the pledge to be a part of this campaign and has worked to create an environment of safety and awareness for its student body. In addition to taking this pledge, Pace University has taken other actions to better educate and protect its' students. Part of these efforts have been conducted through the Office of Sexual Assault Education and Prevention and could not have been possible if not for the late Dean for Students, Dr. Marijo Russell-O'Grady. Together, they worked to facilitate different panels, events, and presentations that bring awareness, destigmatize, and ultimately make Pace University a safer and healthier campus. Particularly of interest for this study was the SAE intervention that was and is being delivered through the mandatory introduction to university life course, called UNV 101, that all incoming students, particularly freshman and transfer students must take and pass.

A standardized UNV 101 curriculum was developed and includes topics around financial management, organization and study skills, mental health and sexual assault education and prevention, among other topics. The SAE consists of six modules that include (1) Introduction to Office of Interpersonal and Sexual Wellness, (2) Confidential and Non-confidential reporting options, (3) Intimate Partner Violence, (4) Affirmative Consent, (5) Sex Positivity, (6) Hands-on

Activity. The entire presentation is about one hour long, and the first five modules are structured as an informational presentation, followed by an opportunity for students to consider their experience with and plans for practicing sexual consent in the sixth module. This intervention is delivered by the office's specialist, who is a social worker with experience in issues of sexual violence, dating violence, and mental health. In addition, a select number of student educators who have been specifically trained by the specialist participate in delivering this intervention. This intervention is knowledge-based with the goal of raising awareness around the modules that are addressed.

Summary

The issue of risky behavior among adolescence as well as the epidemiology of sexual assault among college aged students has been highlighted (RAIIN, 2021; Muehlenhard et al., 2016). Given the trends, research indicated that it is important to better understand adolescent sexual behavior, particularly relating to the use of sexual consent. First, sexual consent can be defined as given when a person freely agrees to do something". In relation to sex, consent should be mandatory every time. Specifically, consent must be freely given, informed, specific, reversible, enthusiastic, and continuous (RAIIN, 2014). One of the major considerations of this paper is the developmental stage of this age group as well as developmentally appropriate interventions. Two major developmental findings stand for late adolescents. The first is given the stage brain development, late adolescents decision making capabilities and ability to decern risk are not fully developed. The second important finding is that adolescent brains are still considered "plastic" providing an additional opportunity to help them make new informational connections. In terms of developmentally appropriate interventions, researchers have shown that providing sexual health education throughout a student's schooling promotes sexual health and

wellbeing (Weaver, Smith, and Kippax, 2005 and Canan and Jozkowski, 2017). Next, this paper discussed a variety of issues that are apparent when discussing sexual consent. To review, these include a lack of knowledge about what consent is or how and when to use it, negative attitudes about the use of consent, ambiguity around the definitions and laws regarding sexual consent, the public's view which critiques social movements and societal expectations around consent, and finally, the laws and policies that states, colleges, and universities have adopted in recent years. Beyond this, sexual health education is often framed to prevent youth from engaging in sexual behavior, focusing on abstinence only teaching. However, the literature provided enumerates on how sexual education can instead be used as a mechanism to empower youth and prevent unwanted sexual encounters. Last, Ajzen's Theory of Planned Behavior (1991) and how it relates to the prediction of health-related behaviors is outlined. This model, which focuses on understanding an individual's intention to act in a certain way, considers attitudes, beliefs, and perceived control. To summarize, the literature has shown the multifaceted issues present when looking at sexual consent in a late adolescent population and how this study aims to fill a gap in the current literature by assessing the effectiveness of a sexual consent education intervention.

Following the literature, the study's primary hypothesis is that sexual consent education intervention will change knowledge, beliefs, and behaviors in first-year college students. More specifically:

- **Hypothesis One: Knowledge of Consent.** Following exposure to the SAE intervention, students' knowledge about sexual consent increase will increase.
- **Hypothesis Two: Positive Attitudes.** Following exposure to the SAE intervention, students' beliefs/attitudes (perceived and injunctive norms) around sexual consent will increase

- **Hypothesis Three. Intent to Consent.** Following exposure to the SAE intervention, students' intention to obtain sexual consent will increase.

Chapter III.

METHODS

Participants

The first wave of data collection included responses from 79 participants. Twenty-nine responses were then excluded from the analysis because of substantial missing or incomplete data. The second wave of data collection included 58 participants; of these 14 were excluded from further analysis due to substantially missing or incomplete data. Although participants were not individually followed across waves, the cohorts can be presumed to be equivalent (Time One n=53; Time Two n=43). Students (79 female, 14 male, 3 non-binary) reported ages between 18 and 19 years old at the time they completed the survey (mean age= 18.3). Overall, most students identify as White (76%), followed by Asian/Pacific Asian (9.4%), Multiracial (6.3%), and Hispanic (4.2%) and Black (4.2%). Additionally, the majority of students were reported to be single at the time of the study (86.5%) followed by individuals who identified as being "in a relationship" (9.4%) with the remainder identifying as "cohabitating" (2.1%). Two participants did not indicate their relationship status.

Students had the opportunity to self-describe their sexual orientation if they did not wish to select from a set of commonly used labels (straight, gay/lesbian, pansexual, asexual, bisexual, queer, questioning). Overall, the majority of students identify as straight (66.7%) with the remainder of students identifying as "not straight" (queer/gay/lesbian=17.7% and bisexual=15.6%).

Given the variety in sexual education around the United States (Williams and Jensen, 2015 and Weaver, Smith, and Kippax), participants were asked in which state they attended high school. Additionally, since the curriculums can differ so widely across the US, students were

also asked about whether sexual consent had been a part of their sexual education curriculum. Over 50% of the participants attended high school in the North (53.1%). The remainder of the students came from a variety of locations throughout the United States as well as outside of the US (south= 22.9%; West= 10.4%, Midwest= 7.3%, US unspecified= 5.2%, outside of US=1%). Furthermore, 85.4% of the participants reported having health education as a part of this high school curriculum. Beyond this, approximately 71% of the participants reported having sex education during high school, however less than half of the students indicated that they learned about sexual consent (47.9%).

Measures

Participants completed a survey battery consisting of questions about (1) demographic information (2) sexual communication ability/capacity (3) current consenting behavior practices and (4) attitudes and belief about sexual consent and sexual consent practices.

Demographics/Participant Characteristics Survey

Participants were asked about their age, gender, relationship status, race, sexual orientation, academic level, and current housing status, and whether they were first-generation college students. Students were also asked if they had been or are currently sexually active. Additionally, participants were asked to provide the state of their high school and whether they had health education and sex education as well as if sexual consent was covered in the curriculum was asked.

Indirect Sexual Communication Scale: An 8-item inventory where items are rated on a six-point Likert scale (1= strongly disagree to 6=strongly agree) that assesses how an individual communicates with a partner about their sexual needs, desires, and boundaries (Theiss & Roi Estlein, 2014). The scale, originally developed to examine sexual communication between

romantic partners, is based on a relational turbulence model that conceptualized sexual communication as how an individual communicates with a partner about their sexual needs, desires, and boundaries (Theiss & Roi Estlein, 2014).

Intentions to Obtain Consent Scale: The Intentions to Obtain Consent Scale is a four-item measure that asks specifically about how one does or does not obtain consent (Hermann et al., 2018). This measure was developed using information based on the Theory of Planned Behavior (Azjen, 1991 and Hermann et al., 2018)

Sexual Consent Scale-Revised: This 44-item scale assesses an individual's beliefs, attitudes, and behaviors about how sexual consent should be and is negotiated between sexual partners. The scale is made up of five subscales that include Behavioral Control ("I think that verbally asking for sexual consent is awkward"), Positive Attitude ("I think it is equally important to obtain sexual consent in all relationships regardless of whether they have had sex before or not"), Indirect Behavioral Approach ("Typically I communicate my sexual consent to my partner using nonverbal signals and body language"), Norms ("I think obtaining sexual consent is more necessary in a new relationship than in a committed relationship") and Awareness ("I have heard sexual consent issues being discussed by other students on campus") (Humphreys & Brousseau, 2010). Each item is rated using a 7-point Likert-type scale (1 = strongly disagree to 7=strongly agree).

Procedures

Sampling. A pool of sections of the mandatory first year college life experience courses that were available for the evaluation study was provided to the researchers by the director of the first-year college experience program. After approaching each section instructor for permission to visit their class, the lead investigator and several research assistants went to the to invite

students to participate in the evaluation study. For the immediate post-intervention data collection, instructors sent an email to their class with the link to the survey within one week of having the intervention. Students were given the opportunity to participate but were informed that it was not mandatory. Students did not receive any extra credit or any other incentives aside from exposure to research by choosing to participate.

Survey Data Collection. Data were collected through an online survey platform, Qualtrics Survey Software. Those who decided to participate were guided to an introduction to the study and then to an informed consent page. After reading the informed consent, those who agreed to participate were taken to the study's survey measures. This set of data is referred to as Time One data.

In order to provide an opportunity for participants to engage in sexual consenting and to allow time for the information from the intervention potentially to be incorporated into students' attitudes and beliefs, a follow up survey, containing exactly the same measures, was distributed to the same group of students who had participated in Time One data collection. Students who were contacted were asked to only complete the follow up survey if they had completed the initial survey. The data collected from this sampling is referred to as Time Two data.

Cohort Analysis. A cohort level analysis was conducted to allow comparison of Time One and Time Two data. This analysis strategy was employed in lieu of a within-subjects design when participant matching data were found to be unreliable. This research asks participants to disclose sensitive information about themselves and their behavior. While anonymity would be desired in this situation, this was impossible to achieve as many individuals involved in the first-year program could reasonably deduce who had participated. Further, demographic characteristics could be readily used to identify specific individuals in the small sample of

participants. A cohort-level analysis also had the advantage of providing some veiling the participants' identities. An analysis of the demographic characteristics of the Time One and Time Two samples indicated that the two cohorts were well matched and could therefore be compared as whole groups.

COVID-19 History Confound

In February 2020, the coronavirus or COVID-19 pandemic began in the United States. Shortly after businesses, schools, work, and in person activities were suspended and stay-at-home lockdown orders were implemented nationwide to reduce the spread of the virus. Due to this, the data collection ceased in April 2020 resulting in a smaller sample size than initially predicted. In addition to this, the results of this study were likely impacted by this pandemic. Since stay-at- home orders and social distancing requirements remained in place, social behaviors such as such as sexual activity, would be impacted and therefore influence the variables in this study. A further discussion on this confound will be explored in the implications section of this paper.

Data Preparation and Statistical Analysis

Hypothesis One: Knowledge of Consent. Students will demonstrate an increase in knowledge about sexual consent. An independent samples t-test was conducted in order to determine if there was a statistically significant difference in Time One and Time Two responses to the Sexual Consent Scale-Revised.

Hypothesis Two: Positive Attitudes. Students' exposure to the sexual consent education intervention will lead to positive attitudes about sexual consent. An independent samples t-test was conducted to determine if there was a statistically significant change between the two data

collection points. Specifically, the independent sample t-test was conducted for the subtest (Scale 2) "Positive attitude toward establishing consent".

Hypothesis Three: Intention to Consent. The intervention will lead to an increase in intention to engage in consenting behavior. An independent samples t-test was conducted to determine if there was a statistically significant difference in Time One and Time Two responses. The independent sample t-tests were conducted on both the Intentions to Obtain Consent Scale as well as the Indirect Sexual Communication Scale.

Descriptive statistical analyses were employed in order to determine the correlations between demographic factors and consenting behavior. Chi-square and crosstabulations were conducted to examine what role factors such as sexual orientation, high school location and education, and housing arrangements have in attitudes beliefs and behaviors having to do with sexual consent.

CHAPTER IV.

Results

Hypothesis One: Knowledge of Consent. The first hypothesis explored if there was an increase in knowledge about sexual consent. Given the knowledge-based interventions and the multifaceted use of the Sexual Consent-Revised scale, an independent sample t-test was conducted for each of the subscales of this measures (see Table 3). Results from each of the tests indicate that there was no statistically significant change in knowledge between Time One and Time Two cohorts. However, it can be noted that in general, mean scores for individual items on each of the subscales was higher than those reported in the original study which utilized this measure. This suggests that the sample examined in this study may already have a stronger foundation in sexual consent knowledge that other college-aged students.

An independent samples t-test was conducted to determine if there was a statistically significant change in students' perception of control in sexual consent. Results comparing Time One (*M=26.80; SD=11.26*) and Time Two (*M=28.39; SD=10.27*) indicated that there was no significant difference in the perception of behavioral control in sexual consent (*t (28), t=. -354, p=.726*). (See Table 3 in appendix)

An independent samples t-test was conducted to determine if there was a statistically significant change in students' positive attitudes towards sexual consent. Results comparing Time One (*M=66.00; SD=8.94*) and Time Two (*M=66.18; SD=6.41*) indicated that there was no significant difference in positive attitudes (*t (29), t=-.059p=.953*). (See Table 3 in appendix)

An independent samples t-test was conducted to determine if there was a statistically significant change in students' indirect behavioral approaches to sexual consent. Results comparing Time One (*M=24.55; SD=8.94*) and Time Two (*M=28.71; SD=1.11*) indicated that

there was no significant difference in students' indirect behavioral approaches as related to knowledge (*t (14), t=-.932, p=.372*). (See Table 3 in appendix)

An independent samples t-test was conducted to determine if there was a statistically significant change in students' knowledge of sexual consent norms. Results comparing Time One (*M=26.80; SD=10.99*) and Time Two (*M=27.16; SD=9.04*) indicated that there was no significant difference in students' knowledge of sexual consent norms (*t (30), t=-.097, p=.923*). (See Table 3 in appendix)

An independent samples t-test was conducted to determine if there was a statistically significant change in students' awareness of and discussions on sexual consent. Results comparing Time One (*M=19,80; SD=5.34*) and Time Two (*M=17.90; SD=6.65*) indicated that there was no significant difference in students' awareness of and discussions on sexual consent (*t (29), t=.864, p=.429*). (See Table 3 in appendix)

Hypothesis Two: Positive Attitudes. An independent samples t-test was conducted to determine if there was a statistically significant change in students' attitudes about sexual consent. Results comparing data from Time One (M=66.00; SD=8.94) and Time Two (M=66.18; SD=6.41) indicated that there was no significant difference in the positive attitudes students held towards sexual consent (*t (29), t=-.059, p*=.953) indicating that the intervention did not lead to an increase in positive beliefs about utilizing sexual consent. (See Table 4 in appendix)

Hypothesis Three: Intention to Consent. The third hypothesis examined whether the intervention would lead to an increase in students' use of sexual consent. An independent samples t-test was conducted on two measures of consenting behaviors. First, the Time One (M=23.45; SD= 3.50) and Time Two Data (M=25.33; SD= 2.27) from the Intentions to Obtain Consent Scale was not found to be statistically significant (*t (30), t=-1.66, p*=.107) indicating

that when asked directly about the utilization of consent, students did not demonstrate a change in their behavior after exposure to the intervention. However, when evaluating Time One (M=41.00; SD= 4.78) and Time Two (M=14.00; SD=4.72) data from the Indirect Sexual Communication Scale a statistically significant difference was found (*t (17), t=12.36, p*=.000**) indicating that communication about sexual consent significantly changed following the intervention. (See Table 5 in appendix)

The Role of Health Education on Sexual Activity

Crosstabulations were conducted in order to explore the relationship between various demographic indicators that were collected. First, a crosstabulation was conducted on participants relationship status and sexual activity (see Table 6). Results from this show that the majority of single participants are sexually active. Furthermore, all other participants who reported an alternative relationship status (i.e., "in a relationship", "cohabitating" or "prefer not to answer") also reported that they were/had been sexually active. In total, nearly 60% of the students who participated in this study are already engaging in sexual activity. Given that about 40% of the participants of this study reported that they have not been sexually active suggests that they may have not had the opportunity to engage in consenting behavior thus impacting the findings of this study. Additionally, given the extensive literature about the vast differences in regulation and implementation of sex education across the United States (Williams and Jensen, 2015 and Weaver, Smith, and Kippax), crosstabulations were conducted to examine the relationship between participants high school locations and the presence of health and sexual education as well as the specific topic of sexual consent being discussed (see Table 7 and Table 8). The results from these tests show that the majority of participants had a general health education in high school regardless of the location. Approximately 83% of the participants who

responded also indicated that they received some form of sex education during high school. Interestingly, about 43% of respondents indicated that they had no exposure to the topic of sexual consent throughout their health/sex ed. curriculum in high school. Exposure to and lack of sexual consent education in high school was equally distributed suggestion that in this sample, location of pre-collegiate education likely did not impact the results of knowledge around sexual consent.

CHAPTER V.

Discussion

This study set out to determine the impacts of a sexual education intervention within a first-year college student population. Specifically, this study sought to find if students' attitudes beliefs and behavior around sexual consent would change after exposure to this intervention. Results from this study provide initial support that sex-based health interventions positively impact college students and elicit direct communication skills when navigating sexual consent. Currently, this is the first known study of its kind to evaluate such a program at the collegiate level. These initial results add to the literature on sexual assault prevention and adolescent sexual health and demonstrate the importance of this such interventions.

The results from this study did not show an increase in students' attitudes about sexual consent. However, previous research has shown that based on the theory of planned behavior, perceived peer sexual attitudes/behaviors and individual sexual behaviors in adolescents and young adults are positively associated (Humphreys and Brousseau, 2010). This suggests that regardless of an intervention, students may base their attitudes and beliefs based on the subjective norms of their peers. This may partially explain why there was no significant change in attitudes about sexual consent. Further, the results from this study indicated that there was no significant difference in students reported sexual consenting behavior. This suggests that exposure to this intervention did not increase students use of sexual consent in their sexual interactions. However, given that about 40% of the participants of this study reported that they have not been sexually active suggests that they may have not had the opportunity to engage in consenting behavior thus impacting the findings of this study. Although direct findings about changes in sexual behaviors were not observed, a significant difference in communication style

was observed in the results of this study. In our findings, we saw that students demonstrated a significant change in their communication style around consent in that they used more directive forms of communication when discussing sex with a partner. The importance of this particular finding is underscored given previous studies that suggest that higher rates of sexual assault may be partially attributed to what is known as miscommunication theory which relates to types of non-verbal cues of consent (Hermann, Liang, and DeSipio, 2018). Furthermore, this finding is particularly interesting given that there was no change in attitudes about sexual consent which was attributed to norms among this group. Prior research in this area indicated that indirect communication as a means of consent represent the subjective norm of this population (Humphreys and Brousseau, 2010). Therefore, given this information from prior research and the null findings in hypothesis one, we would have not particularly expected to see an increase in directive communication about sexual consent. Since this was the only significant finding in this study, further considerations should be made about future research aims, as this suggests this may be a target topic area for this population and the receptiveness of the intervention. Beyond this, the exploratory findings of this study show that exposure to versus lack of sexual consent education in high school was fairly equally distributed suggesting that in this sample, location of pre-collegiate education likely did not impact the results of knowledge around sexual consent.

Limitations

There are several limitations that should be considered when reviewing the results of the current study. First, the primary limitation of this study was the method of sampling. This study lacked the ability to perform a random sampling. In addition to the method of sampling, the study design, which relied on a post-posttest design was a limitation. Instead, utilizing a pre-post-posttest model or including a within-subjects design would provide more accurate baseline

information and more reliable data. Further, the sample size in each of the data sets was minimally sufficient to produce valid results. An additional limitation of this study includes the lack of a diverse and representative sample. Although the population of the university sampled is predominately white and female, which matches the majority of this study's sample, the lack of diversity limits the generalizability of the results of this study. Furthermore, due to time constraints and the impact of the global pandemic, the data collection that had been initially planned was skewed. Future studies may benefit from collecting data at a time when students are engaging in social behaviors or when the impacts of the pandemic can be included in the analysis. Nonetheless, this study provides important information about sexual consent interventions. The findings of this study suggests that school administrators need to consider the importance of sexual consent education for their student body. Rather than writing tone deaf policies that students rarely utilize, administrators must think about not only incorporating interventions but also implementing program evaluations in order to continue to understand the nuances around late adolescent sexual behavior. By furthering initiatives such as these we are supplementing the development of our late adolescents and ensuring we prepare them to live healthy lives and safely engage in sex positive behaviors.

Implications for School and Clinical Child Psychology

The findings from this study will help to guide both clinical child psychologists as well as professionals who work within a school system. This study is the first known of its kind, to evaluate a school-based sexual health education intervention for late adolescents. Previous research has highlighted the need for further understanding about sexual health education as a means of promoting healthy adolescents (Fantasia, 2011). This study begins to show the ways in which college-age students respond to school-based interventions related to sexual health. This

study also works to showcase the importance of considering a developmental prospective when educating youth about sexual wellness and consent. Offering consent education to students at developmentally appropriate levels is suggested throughout the literature, by health professional, and confirmed in this study (Canan and Jozkowski, 2017). Beyond this, the implications of sexual assault are extreme. Various studies show that an individual who experiences sexual assault will likely experience higher levels of psychological distress, suicidal ideation, and other adverse mental outcomes such as anxiety and depression (Newins et al., 2020 and Carey et al., 2018). Considering that 80 percent of all individuals who have experienced sexual assault are under the age of 30, offering education as not only an intervention, but also as a method of prevention throughout an individual's schooling (k-12+) would prove to be beneficial (RAINN, 2014). Given these statistics, it is likely that most clinicians and school professionals will encounter students and/or patients with this type of trauma history. This study adds to the literatures and creates as a means for these professional to extend their knowledge in this area, which could be used to inform their clinical practice. This study provides insights for educators, school administration and clinicians in support of developing and implementing sexual health school-based interventions.

Future Directions

There are also several considerations that should be made for future studies in this area. First, one of the limitations in this study was that the primary investigator of this project has limited input on the health-based intervention. Although the university consulted an outside expert agency, for research purposes it would be beneficial to have more control of the intervention so that additional measures of effectiveness can be planned for. Additionally, in this vein, future studies would benefit from evaluating interventions that go beyond knowledge based and also

use evidence-based programing. Future research projects could also to plan to invest the time and resources beyond the scope of this doctoral project to execute longitudinal studies to examine how knowledge, attitudes and beliefs change across the four years of college. Research suggests that a large brain maturation during this particular developmental period (late adolescence; 18-23 years of age) has implications for social cognitive and executive abilities; therefore, one would expect some difference to be found in a longitudinal study (Taylor et al., 2014). In contrast, other studies may begin to explore what consent intervention programs look like for younger populations, such as high school students to understand where gaps in knowledge may be when students arrive at college. Lastly, given the lack of diversity in the present sample, future studies should actively recruit a more diverse sample to gain a better understanding of knowledge, attitudes, and behaviors in males, races other than white, and the LGBTQ+ populations.

Other issues related to this topic that should be considered for future research are mental health outcomes of adolescents who engage in sexual behavior with/without the use of consent. Further, given that sex is often viewed as a taboo topic, interventions and research should focus on how to destigmatize it and make it more accessible. Lastly, future research and interventions may also focus on how to give individual an opportunity to "practice" the given behavior. Since this is related to sexual engagement, and there is a range amongst college age students in their sexual activity, it would be valuable to extend the idea of "consenting" beyond sexual encounters. This would provide the opportunity to not only make the intervention less taboo but also, give youth the chance to practice and become curious about questions that may arise in order to continuing the education process.

Conclusion

While not all the hypotheses in this study were confirmed, almost most importantly, this study demonstrated that interventions delivered to first year college students significantly impacts the way they communicate about sexual consent. Previous studies have shown that this age group generally engages in non-verbal and non-directive methods of sexual consent which can lead to ambiguous and confusing sexual situations (Jozkowski & Peterson, 2013). The current study indicates that after exposure to the intervention, students report engaging in more directive and clear methods of communication around sexual consent. This is the first known study of its kind to evaluate a sexual consent education program in a college population. Evaluating the effectiveness of programs is an essential component of interventions and research in this area. By doing so, this study has set the precedent for this university and others to be more thoughtful and active in ensuring that the curriculum being delivered to students is actually useful. Interventions similar to the one in this study and the ones in the future should not only educate students about sexual violence prevention but also integrate ideas about sex positivity and how to navigate the pleasure aspects as well.

Table 1. *Descriptive Statistics – Participant Demographics Time One Data (n=53)*

Demographic	***n***	***%***
Age		
Eighteen (18)	39	79.6
Nineteen (19)	10	20.4
Gender		
Woman	44	83
Man	7	13.2
Non-Binary	2	3.8
Race		
White	39	73.6
Hispanic	3	5.7
Black	3	5.7
Asian/Pacific	5	9.4
Multiracial	3	5.7
Sexual Orientation		
Straight	33	62.3
Queer/Bisexual/Gay/Lesbian	20	37.7
Relationship Status		
Single	48	90.6
In a relationship	3	5.7
Cohabitating	1	2.3
Prefer not to answer	1	2.3
Location of High School		
Northeast	26	49.1
South	11	20.8
West	7	13.2
Midwest	4	7.5
US unspecified	4	7.5
Outside US	1	1.9
Health Education		
Yes	45	84.9
No	8	15.1
Sex Education		
Yes	37	82.2
No	8	17.8
Sexual Consent Education		
Yes	23	52.3
No	21	47.7
Sexually Active		
Yes	28	52.8
No	25	47.2
Housing		
On Campus	44	83
Off campus with family	6	11.3

Off campus without family	3	5.7
Student Group		
Yes	26	49.1
No	27	50.9
First Generation		
Yes	11	20.8
No	42	79.2

Table 2. *Descriptive Statistics – Participant Demographics Time Two Data (n=43)*

Demographic	***n***	***%***
Age		
Eighteen (18)	22	57.9
Nineteen (19)	16	42.1
Gender		
Woman	35	81.4
Man	7	16.3
Non-Binary	1	2.3
Race		
White	34	79.1
Hispanic	1	2.3
Black	1	2.3
Asian/Pacific	4	9.3
Multiracial	3	7
Sexual Orientation		
Straight	31	72.1
Queer/Bisexual/Gay/Lesbian	12	27.9
Relationship Status		
Single	35	81.4
In a relationship	6	14
Cohabitating	1	2.3
Prefer not to answer	1	2.3
Location of High School		
Northeast	25	58.1
South	11	25.6
West	3	7
Midwest	3	7
US unspecified	1	2.3
Outside US	0	0
Health Education		
Yes	37	86
No	6	14
Sex Education		
Yes	31	83.8
No	6	16.2
Sexual Consent Education		
Yes	23	62.2
No	14	37
Sexually Active		
Yes	29	67.4
No	14	32.6
Housing		
On Campus	33	76.7
Off campus with family	8	18.6

Off campus without family	2	4.7
Student Group		
Yes	30	69.8
No	13	30.2
First Generation		
Yes	8	18.6
No	35	81.4

Table 3. Independent Sample t-test for Knowledge of Consent (Hypothesis 1)

	Time One		Time Two		
	M	SD	M	SD	*t-test*
Bx Control	26.80	11.26	28.39	10.27	.726 (ns)
Pos. Attitudes	66.00	8.94	66.18	6.41	.953 (ns)
Indirect Bxs	24.55	11.79	28.71	1.11	.372 (ns)
Norms	26.80	10.99	27.16	9.04	.923 (ns)
Awareness	19.80	5.34	17.90	6.65	.395 (ns)

***p<.01.*
Note. M=Mean. SD=Standard Deviation.

Table 4. Independent Sample t-test for Positive Attitudes Towards Establishing Consent (Hypothesis 2)

	Time One		Time Two		
	M	SD	M	SD	*t-test*
Pos. Attitudes	66.00	8.94	66.18	6.41	.953 (ns)

***p<.01.*
Note. M=Mean. SD=Standard Deviation.

Table 5. Independent Sample t-test for Intentions to Engage in Consenting Behavior (Hyp. 3)

	Time One		Time Two		
	M	SD	M	SD	*t-test*
Intention to Obtain	23.45	3.50	25.33	2.27	.107 (ns)
Indirect Sex Comm.	41.00	4.78	14.00	4.72	.000**

***p<.01.*
Note. M=Mean. SD=Standard Deviation.

Table 6. Crosstabulation of Relationship Status and Sexual Activity

Relationship status*Sexual Activity Crosstabulation (n=96)

	Sexually Active		Not Sexually Active	
	n	%	n	%
Single	44	46%	39	41%
In a relationship	9	9%	0	0%
Cohabitating	2	2%	0	0%
Prefer not to answer	2	2%	0	0%

Table 7. Crosstabulation of High School Location and the Presence of Sexual Education

High school location*Sex education Crosstabulation (n=96)

	Sex Ed Yes		Sex Ed No	
	n	%	n	%
Northeast	41	42%	6	6%
South	12	13%	4	4%
West	6	6%	1	1%
Midwest	4	4%	2	2%
US Unspecified	4	4%	1	1%
Outside of US	1	1%	0	0%

Table 8. Crosstabulation of High School Locations and the Presence of Sexual Consent Education

High school location*Sex consent education Crosstabulation (n=96)

	Consent Ed		No Consent Ed	
	n	%	n	%
Northeast	28	29%	19	20%
South	9	9%	6	6%
West	3	3%	4	4%
Midwest	3	3%	3	3%
US Unspecified	3	3%	2	2%
Outside of US	0	0%	1	1%

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