— LITERATURE REVIEW —

HEALTHY SEXUALITY EDUCATION AS CHILD SEXUAL ABUSE PREVENTION

Abstract: This literature review analyzes healthy sexuality educational efforts to determine whether promoting healthy sexuality is an effective tool for primary prevention and risk reduction of childhood sexual abuse. This literature review examines English-language articles and sexuality education curricula from 1984 to 2015 to determine if their content encourages healthy sexuality and what, if any impact this had on preventing childhood sexual abuse among participants. Little published research examines the impact that healthy sexuality education has had on child sexual abuse perpetration or victimization. What research does exist suggests that healthy sexuality education has promise as a tool for prevention. Additional research, including in-depth, large-scale evaluations of sexuality education programs, is needed to determine whether or not they result in the primary prevention or risk reduction of child sexual abuse.

This literature review examines research on healthy sexuality programs targeting children and adolescents. This review draws upon English-language research from 1984 to 2015 on sexuality education programs that promote healthy sexuality. This literature review seeks to support or reject the hypothesis that healthy sexuality educational efforts are effective tools for promoting primary prevention and risk reduction of childhood sexual abuse.

Comprehensive sexuality education programs targeting children and youth are increasingly including content on healthy sexuality alongside content on STDs, pregnancy, reproductive health, and sexual violence. A small number of studies suggest that healthy sexuality education holds promise as a tool for abuse prevention and risk reduction. However, more research is needed to determine whether or not healthy sexuality messaging is an effective means of preventing sexual abuse.

SEXUAL VIOLENCE PREVENTION & RISK REDUCTION

Sexual violence risk reduction is sometimes confused with primary prevention, so clarification of the two terms is necessary. Sexual violence risk reduction refers to efforts to decrease one's risk of sexual victimization. Primary prevention refers to efforts to prevent the perpetration of sexually abusive acts before they occur (Centers for Disease Control and Prevention [CDC], 2004). For example, a sexuality education program that teaches participants to be mindful of their personal boundaries and say "no" to unwanted sexual activity would constitute sexual assault risk reduction. On the other hand, a sexuality education program that urges participants to respect the sexual boundaries of others and refrain from perpetrating coercive sexual acts would constitute primary prevention.

The social-ecological model of violence prevention examines interactions between individuals, interpersonal relationships, community, and society. This model allows stakeholders to understand sexual violence as a complex social phenomenon and develop prevention strategies that target multiple tiers of society (CDC, 2009).

Social norms about sexual violence shape attitudes and behavior, and thus sexual violence prevention efforts must influence norms on multiple tiers of society. The Spectrum of Prevention tool lists six levels of society that comprehensive primary prevention efforts must target: individual knowledge and skills, community education, provider education, coalitions and networks, organizational practices, and policies and legislation (Davis, Parks, & Cohen, 2006). Sexuality education programs that promote healthy sexuality and condemn sexual violence attempt to impact the first three societal levels.

DEFINING HEALTHY SEXUALITY

Models used to frame healthy sexuality promotion include ecological models, vulnerability-resiliency models, and family system models. Ecological models hypothesize that traits of individuals and their environments (i.e., school, neighborhood, community) influence behavior and bring about behavioral changes. Vulnerability-resiliency models suggest that personal resilience and protective factors can offset risk factors, which include psychological, physical and social realities correlated with negative outcomes. Finally, family system models approach individuals as they are embedded within family systems, examining ways in which families and familial roles impact persons (Brooks-Gunn & Paikoff, 1991).

Discussions around healthy sexuality overlap with sexual health and sexual rights, and the terms “healthy sexuality” and “sexual health” are sometimes used interchangeably (World Health Organization [WHO] and United Nations Population Fund, 2010). The two terms are related but distinct. Sexual health is a state of mental, emotional, physical, and social well-being in terms of sexuality, requiring a respectful and positive approach to sexuality and relationships. The sexual rights of all persons must be respected and defended in order for sexual health to be attained. Sexual rights are informed by human rights recognized by international human rights documents. Sexual rights include but are not limited to freedom from coercion and violence, the right to bodily integrity, the right to pursue a safe and satisfying sexual life, the right to choose one’s partner, the right to decide whether or not to be sexually active, the right to access information and education on sexuality, and the right to access sexual and reproductive health services (WHO, 2006).

Consultation between the World Health Organization and the World Association for Sexology in 2002 concluded that sexual health programs should be informed by several key principles including respect for privacy, autonomy, and self-determination, accountability, awareness of the changing needs of all sexes throughout the lifespan, awareness of cultural diversity, and positive and affirming approaches to sexuality (WHO, 2006).

It is important to note that the sexual health field's understanding of healthy sexuality continues to evolve. For instance, at a technical consultation between the World Health Organization and the United Nations Population Fund in 2007, 21 social development stakeholders, medical experts, researchers, and educators discussed and refined indicators of sexual health. Stakeholders argued that, by themselves, pleasure and informed choice are not indicators of positive sexuality and sexual health. Activities undertaken as informed choices do not necessarily result in health-promoting behaviors (i.e., choosing to have sex with an HIV-positive partner without a condom). Sexual autonomy can also be a problematic concept, they observed, and thus autonomy by itself is not an indicator of positive sexuality and sexual health. For instance, a woman may "autonomously" engage in prostitution, but her decision to do so may be heavily influenced by economic pressures. Thus, the definition of positive sexuality and sexual health must be broader, stakeholders decided. The stakeholders proposed broader indicators of positive sexuality and sexual health, including the capacity to make informed choices, satisfaction with one's sexual expression and sexual identity, and the absence of violence, coercion, and discrimination (WHO and United Nations Population Fund, 2010).

The World Association for Sexual Health emphasizes that universal access to comprehensive sexuality education is vital for encouraging sexual health. The *Sexual Health for the Millennium* declaration states that all member organizations of the World Association for Sexual Health will recognize and promote sexual rights for all, promote gender equality, combat all forms of sexuality-related violence (including sexual violence and coercion), and provide universal access to comprehensive sexuality education (World Association for Sexual Health, 2008).

Some experts have developed broader conceptions of healthy sexuality that define specific dimensions of sexuality. The Circles of Sexuality model developed by Dennis Dailey informs the *Life Planning Education* and *Our Whole Lives* curricula. The Circles of Sexuality model expresses sexuality through four circles: *sensuality* (a broad category that includes body awareness, body image, and fantasy), *intimacy* (emotional closeness and mutuality with others), *sexual identity* (understanding who one is sexually, including one's sense of gender, gender expression, and sexual orientation), and *sexual health and reproduction* (sexual behaviors, physical sexual health, and reproductive processes). A fifth circle, sexualization (use of sex or sexuality to control and manipulate others), can cover a number of attitudes and behaviors that range from harmless, such as flirting, to highly destructive, such as rape (Advocates for Youth, 2008).

The Manley model expressed healthy sexuality through five categories: *sexual personhood* (the state of being a sexual being, including chromosomal and anatomical sex, gender identity, and sexual orientation), *sexual relationships, sexual behaviors, sexual physical and biological capabilities* (physical and biological responses related to sexuality), and *sexual spirituality* (the connection between one's sexuality and something greater than oneself from which one draws energy, validation, and sustenance) (Manley, 1995).

Social-ecological models place healthy sexuality into individual, interpersonal, community, and societal dimensions. The interpersonal dimension of healthy sexuality as cultivated within families is a focus of family social science professor James W. Maddock. Maddock (1989) argues that the family sexual experience is characterized by five suppositions. First, sex exists within the structure and

organization of the family unit, in that erotic interest forms the motivation for the creation of the family. Second, the family transmits messages about acceptable behaviors associated with gender. Third, members of the family system meet their physical, psychological, and social needs through physical and emotional interaction with each other. Forth, the psychosexual development of family members leads to changes in the form and function of the family over time. Finally, behaviors and meaning within the family system are shaped by forces in the surrounding environment, such as history and culture.

Healthy family sexuality, Maddock claims, is defined as the expression of sexuality within the family in ways that enhance the sexual health and personal identities of members and encourage a coherent family system. In Maddock's model, family sexual health characterized by shared culturally relevant sexual values, respect for both genders, effective communication, interdependence, personal interaction that which promotes members' capacity for affection and intimacy, and appropriate physical and psychological boundaries between members. Maddock's model is egalitarian in that both male and female family members can influence decision-making, exercise self-control, maintain boundaries, and initiate action. Children are individuals whose sexuality should be respectfully and appropriately nurtured within the family system, rather than exploited (Maddock, 1989).

Sexually unhealthy families are characterized as either sexually neglectful or sexually abusive in Maddock's model. Sexually neglectful families ignore the sexuality of members and are characterized by rigid gender roles, disgust toward bodies, and sexual expression as a solely procreative activity. Sexual activity between spouses is characterized by a lack of communication and creativity. At the other extreme are sexually abusive families, characterized by pervasive boundary violations and/or excessively rigid boundaries. Such families are characterized by thin boundaries between members (increasing the risk of enmeshment and poor self-differentiation), boundary confusion between younger members and older members, excessively thick boundaries between the family unit and the outside world, rigid gender roles, and male control over other family members. Sexual violence and exploitation may be present in such family systems (Maddock, 1989).

Advocates from the sexual violence prevention field have called attention to healthy sexuality as the antithesis of coercive sexuality. In theory, sexual rights and healthy sexuality principles are incompatible with sexual violence and attitudes that condone sexually abusive behaviors. Sharon Lamb argues that sexual perpetrators are ill-informed about human sexuality, and that this ignorance fuels unhealthy attitudes toward sex. To reduce sexual violence, she argues, sexuality educators should discuss sexual pleasure as something more than genital pleasure, teach that fantasy is normal, discuss sexual harm and consent, and stress values such as concern and consideration as elements of healthy sexual behavior (Lamb, 1997).

Writing for ***Moving Upstream***, Brad Perry argues that sexual violence involves distortion and corruption of one's sexuality. Healthy sexuality offers an alternative model of sexuality amidst pervasive societal messages about unhealthy sexuality. He defines healthy sexuality as the responsible and voluntary expression of one's sexuality in a way that enriches others, free from disease, dysfunction, and coercion. Healthy sexuality is a facet of one's physical, psychological, and social well-being, and therefore is to be expressed in ways that reflect personal and social ethics. Traditional unhealthy messages — such as the idea that sexuality is an

expression of human weakness, a heterosexual male conquest, or an adversarial encounter between the sexes – divorce sexuality from one's humanity and thus ignore sexuality's role as a facet of one's personhood (Perry, 2005).

With the above definitions and dialogues in mind, this literature review defines health sexuality as capacity to control, enjoy, and understand one's sexual behavior in responsible ways that promote personal and social well-being. Healthy sexuality is characterized by consent, personal boundaries, respect for one's sexual rights and the sexual rights of others, tolerance of different forms of sexual expression, and a view of sexuality as fundamentally natural and positive.

HEALTHY SEXUALITY AND SEXUAL HEALTH PROGRAM PRINCIPLES

U.S. and global stakeholders have outlined principles that should inform sexuality education and sexual health programs. Major stakeholders recommend that programs promote sexual rights and embody values compatible with healthy sexuality as defined above. For example, the World Health Organization emphasizes sexual rights in the principles that should undergird sexual health programs around the world. In its 2010 guide on developing sexual health programs, the World Health Organization states that sexual health is characterized by well-being, safety, respect, freedom from violence, and realization of human rights. Furthermore, it states that sexual health is relevant throughout the lifespan and expressed through diverse sexualities and means of sexual expression. Sexual violence, it argues, is not only a sign and a result of gender discrimination, but an affront to the victim's right to life and physical integrity. Sexual health programs must discuss the roots of sexual violence as well as the psychological, medical, and economic needs of victims. (WHO, 2010).

In a 2010 report, the World Health Organization Europe and Federal Centre for Health Education outlined key concepts related to sexual behavior that it encourages in sexuality education programs. These key concepts include but are not limited to messages that promote healthy sexuality:

- Sexuality has biological, psychological, spiritual, social, and ethical dimensions.
- When expressed in a manner that is respectful toward others, sexuality can enhance one's well-being.
- People have the capacity to enjoy their sexuality throughout the lifespan.
- Sexual feelings and fantasies are normal and natural, occurring throughout the lifespan. However, not all people choose to act on feelings and fantasies.
- Sexual interests can change throughout one's life, as can sexual expression.
- People should respect and tolerate different forms of sexual expression across settings and cultures.
- Physical affection such as kissing, touching, and sexual behaviors are ways that people show love, enjoy physical intimacy, and seek pleasure. However, children are not ready for sexual contact with others.
- Sexual violence is wrong, as well as a violation of human rights (World Health Organization Europe and Federal Centre for Health Education, 2010).

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In the U.S., the national sexuality education standards put forth by the Future of Sex Education Initiative and collaborating organizations are designed to ensure that programs present sexual development as a natural, healthy aspect of human development. The standards are grounded in the social ecological model of prevention as well as social learning theory, which posits that learning takes place in particular social contexts and is shaped by social norms.

According to their standards, sexuality education programs should teach knowledge and personal skills that foster healthy sexuality. The document uses healthy sexuality and sexual health interchangeably, acknowledging that sexual health has physical, mental, emotional, and social dimensions. The document focuses on anatomy/physiology, personal identity, reproductive matters, healthy relationships, and personal safety as aspects of sexual health that sexuality education programs should address. The standards also instruct programs to define and condemn sexual violence, sexual harassment, and sexual coercion (The Future of Sex Education Initiative, 2011).

In a broad sense, by calling on sexuality education programs to present sexual development as natural and healthy, acknowledging the multiple dimensions of sexual health, and incorporating issues such as sexual identity, respect, boundaries, safety, and healthy relationships, the standards promote a vision of sexuality that is compatible with healthy sexuality.

Additionally, the National Guidelines Task Force under the Sexuality Information and Education Council of the United States (SIECUS) regularly releases its own set of guidelines for comprehensive sexuality education. The values expressed in the 2004 guidelines acknowledge that all humans are sexual beings who can express their sexuality in a variety of ways, and that sexuality encompasses physical, emotional, spiritual, social, and ethical dimensions. The guidelines emphasize the inherent dignity and worth of all persons, the right of all persons to make responsible sexual choices, and sexuality as a natural and healthy part of life. Sexual relationships, the guideline values state, should be respectful, reciprocal, and free of coercion and exploitation.

The SIECUS guidelines also outline life behaviors that programs should teach students, which reflect values associated with healthy sexuality. For examples, students are to be taught that sexuality is an aspect of a person's total well-being, people can enjoy and express sexuality throughout life, sexuality is to be expressed in ways that are compatible with one's values, and that sexual feelings are natural. Students are to be taught to respect the rights of others, distinguish life-enhancing sexual behaviors from behaviors that are harmful to oneself and others, and engage in sexual relationships characterized by consent, honesty, protection, pleasure, and the absence of exploitation. (National Guidelines Task Force, 2004)

Healthy sexuality does not exist in a vacuum, but rather takes form and expresses itself in a social landscape. Holistic approaches to healthy sexuality recognize that social well-being, alongside physical, emotional, and mental well-being, is an essential component of sexual health. The Oregon Youth Sexual Health Plan published by the Oregon Department of Human Services acknowledges that inequality can have a detrimental impact on the sexual development of youth. Thus, the plan advocates for policies that reduce rigid gender role expectations, gender inequality, discrimination, heteronormativity, and poverty as part of an overall strategy for supporting young people's sexual development (Oregon Department of Human Services, 2009).

TRAUMA-INFORMED APPROACHES TO HEALTHY SEXUALITY

For children and youth who have already experienced sexual abuse, healthy sexuality messages are especially relevant. Childhood sexual abuse is correlated with higher risk for negative sexual health outcomes in adulthood, including high-risk sexual behaviors, less sexual satisfaction, and more sexual anxiety (Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012). Supportive measures for childhood sexual abuse survivors, including healthy sexuality messages, may help survivors avoid negative sexual health outcomes and cultivate healthy sexual lives.

Trauma-informed approaches can serve as useful means of teaching victimized children and youth about healthy sexuality. Nicole M. Fava and Laina Y. Bay-Cheng discuss the importance of trauma-informed sex education as a means of teaching healthy sexuality. They observe that trauma interventions for childhood sexual abuse victims often lack comprehensive content on healthy sexuality. Trauma-informed sex education, they argue, can equip sexual abuse victims with tools for recognizing their sexual agency, avoiding negative sexual experiences, and cultivating positive sexual experiences. Sex educators are encouraged to acknowledge the impact of sexual trauma on youth, recognize the importance of physical and psychological safety for trauma survivors, and empower their students (Fava & Bay-Cheng, 2013).

SEXUALITY EDUCATION FOR CHILDREN AND YOUTH

Multiple sexuality education programs intended for children and youth in North America and abroad promote healthy sexuality as defined above. However, almost no published research has explored the relationship between promoting healthy sexuality to youth, primary prevention of sexual violence, and risk reduction of sexual violence.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) conducted research on multiple sexuality education programs across the globe. However, the report focused on sexuality education as a cost-effectiveness measure and did not explore healthy sexuality education's impact on sexual violence. While the report stated that comprehensive sexuality education is an effective tool for preventing sexual violence, it did not provide data to corroborate this claim. (UNESCO, 2011)

Earlier research on sexuality education showed little impact on attitudes toward sexual violence, but such research is incomplete. In a report on school-based and community-based sexuality education programs, Douglas Kirby presents data on sexual force and pressure from students at two U.S. high schools. Among the programs profiled in the report was the sexuality education program presented at Council Rock High School in Bucks County, PA. The program consists of a junior sexuality education course and a senior

sexuality seminar. The philosophy underpinning the program contained principles compatible with healthy sexuality, including the idea that each person is a sexual being, healthy self-esteem prevents people from being exploited or exploiting others, and people are deserving of respect regardless of sex, age, class, race, or beliefs. Additionally, the 12th grade seminar explores different dimensions of sexuality, such as making sexual decisions, sexual identity and orientation, and sexual violence. However, the report did not include enough information to determine to what extent the programs evaluated promoted healthy sexuality as defined above (Kirby, 1984).

In a survey of 398 11th grade students who took the Council Rock High School sexuality education course, students exhibited a very small increase in opposition to the use of force or pressure in sexual activity. However, this increase was not statistically greater than that of the control group which took a general health class. Similarly, a survey of 342 12th graders who participated in the sexuality seminar revealed a small but statistically insignificant increase in opposition to the use of force or pressure in sexual activity, compared to the control group (Kirby, 1984).

Ferndale Elementary School and High School in Ferndale, CA provide sexuality education course units to 5th and 6th grades, 9th and 10th grades, and 11th and 12th grades. A survey of 10 12th grade students demonstrates a statistically significant increase in opposition to use of force or pressure in sex, compared to the control group of 37 students. However, the small sample size used for the Ferndale High School sample makes these results problematic. (Kirby, 1984)

More recently, the Virginia Sexual & Domestic Violence Action Alliance reviewed sexual health programs that contained sexual violence primary prevention components. The organization identified 35 healthy sexuality resources such as curricula, activity guides, policy initiatives, and media. Six of these resources were found to contain information on sexual violence prevention and sexual health promotion. Four of the six were deemed "promising," but none could be deemed "evidence-based" due to the dearth of outcome evaluation data. These four included ***Our Whole Lives Lifespan Sexuality Education Curricula, Life Planning Education, Care for Kids***, and ***Family Life and Sexual Health*** (FLASH).

Our Whole Lives is scheduled to take part in a three-year longitudinal outcome evaluation. The authorship awaits information from Advocates for Youth on evaluation findings for ***Life Planning Education*** (Perry, 2011).

The ***Our Whole Lives Lifespan Sexuality Education Curricula*** is based on ***Guidelines for Comprehensive Sexuality Education*** produced by the National Guidelines Task Force, and is published by the Unitarian Universalist Association and the United Church Board for Homeland Ministries. Our Whole Lives is a comprehensive sexuality education curriculum with age-appropriate programs for students in grades K-12, as well as an adult program for persons ages 18-35. Content for younger learners includes body appreciation, boundaries (i.e., appropriate versus inappropriate touch), and respect for diversity (Sprung, 1999).

Currently, no evaluation of the youth component of ***Our Whole Lives*** has explored the program's impact on the primary prevention and risk reduction of sexual violence. However, the ***Our Whole Lives*** Evaluation and Promotion Project, a partnership between the Indiana University School of Medicine and Christian Community, is preparing for an evaluation of ***Our Whole Lives*** (n.d.).

Life Planning Education, developed by Advocates for Youth, is a sexuality and family life education program intended for adolescents age

13-18. The most recent edition of the program available for download from the Advocates for Youth website was published in 1995, but the website notes that the curriculum is currently being revised. The program includes content on sexuality, relationships, parenting, and community responsibility in a manner that promotes healthy sexuality. Chapter 5 of the ***Life Planning Education*** curricula discusses sexuality through the life span, encourages comfort talking about sexuality and sexual orientation, and features the Circles of Sexuality model developed by Dennis Dailey. Additionally, chapter 11 discusses sexual violence and family violence, contains content for understanding and preventing date rape, and explores strategies for avoiding violent or abusive situations. (Advocates for Youth, 1995) No published research has explored what, if any impact ***Life Planning Education*** has had on the primary prevention or risk reduction of sexual abuse.

Care for Kids emerged from the Prescott Child Abuse Advisory Committee, a response to widespread allegations of child sexual abuse in Prescott, Ontario in 1989. The curriculum was created to promote primary prevention of sexual violence through the promotion of healthy sexual behavior. Currently, the program contains content for children ages 3-8 (The Leeds, Grenville and Lanark District Health Unit, 2005).

The goal of ***Care for Kids*** is to encourage comfort with sexuality and healthy relationships, which will in turn foster a family environment that encourages health sexual behavior and responsible sexual decision-making. The principles that infuse ***Care for Kids*** (The Leeds, Grenville and Lanark District Health Unit, 2005) include but are not limited to:

- Physical bodies are good and deserving of respect and care.
- Body parts have names and can be discussed in a respectful manner.
- Males and females do not always have to conform to stereotypical gender roles. (This was added to prevent perpetrators from using gender stereotypes to silence children.)
- Adults and older children have no reason to “play” with a child’s private areas.
- Touching can be enjoyable, but it is acceptable to say no to any kind of touching.
- One should respect the boundaries of others by refraining from touching them if they do not want to be touched.
- Touching should not be kept secret.
- All kinds of feelings are acceptable, and if children feel confused about their feelings, they can ask adults for help.

Prevent Child Abuse Vermont carried out an evaluation of the ***Care for Kids*** program at 14 sites during the 2013-2014 academic year. Evaluators conducted pre- and post-test assessments of 396 children in pre-school, kindergarten, and first and second grade who were exposed to the ***Care for Kids*** program. After exposure to the program, children showed statistically significant increases in all twelve s ocial and emotional indicators measured, including “demonstrates understanding that genitals are private”, “says ‘no’ when he/she does not want to be touched”, and “accepts a ‘no touching’ answer from others”. Thus, the evaluation suggests that ***Care for Kids*** was successful in teaching children about healthy sexual behavior, such as personal boundaries and respect for others (Prevent Child Abuse Vermont, 2014).

Finally, the ***Family Life and Sexual Health (FLASH)*** curriculum is a comprehensive sexuality education curriculum distributed by the Seattle & King County Public Health Department (2012). The program is rooted in social learning theory and contains activities related to cognitive, behavioral, and environmental aspects of sexuality. Additionally, the sexual violence prevention lessons are informed by the social-ecological model of violence prevention, and address factors related to sexual violence in relationships, the community, and society.

FLASH curriculum content presents sexuality and healthy touch as positive, includes information on sexual minorities, and teaches students about sexual violence in a manner meant to address both victimization and perpetration. Among the objectives of the "Sex: Myths, Facts, Feelings & Values" section of ***FLASH's*** 9-12 grade program are that sexuality and sexual response are a gift, sexual information is to be presented in a positive manner, and a wide range of healthy and normal bodies and sexual responses exist. The sexual violence prevention unit of the 9-12 grade program also discusses consent, cues that signify consent, and strategies for helping those at risk for sexual victimization or perpetration. An "LGBT Youth" unit defines terminology relevant to lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons, dispels myths about LGBTQ people, and condemns anti-LGBTQ violence and harassment. Additionally, the "Touch and Abstinence" unit of the 7-8 grade program presents touch as a basic need. The unit contrasts healthy, nurturing types of touch from violent and exploitative forms of touch (Seattle & King County Public Health Department, 2012).

No large-scale, in-depth evaluation of the *FLASH* curriculum has been conducted, and no published research has examined what, if any, impact *FLASH* has had on primary prevention or risk reduction of sexual violence.

Global sexuality education programs that promote healthy sexuality can also be considered promising, but a dearth of research makes it difficult to assess their impact on sexual violence primary prevention and risk reduction. For example, the ***It's All One*** program, published by the Population Council, promotes sexual rights and healthy sexuality values to adolescents. The curriculum is grounded in the belief that gender equality and human rights promotion are essential to helping people enjoy healthy sexual lives (Population Council, 2009). ***It's All One*** maintains that all people have the right to control and protect their own bodies, to be treated with respect and dignity, to develop a positive attitude toward their bodies and sexuality, and to be free from sexual abuse. Grounded in sexual rights, the curriculum notes the importance of access to accurate information and services related to sexual and reproductive health. Sexuality is presented as a source of health and pleasure, when expressed alone or in a mutually consenting and respectful interaction with a partner. Among the topics covered by ***It's All One*** are LGBTQ persons, the unacceptable nature of homophobia, and the many ways that people experience sexual desire (International Sexuality and HIV Curriculum Working Group, 2011).

Research suggests that educators and service providers have had positive experiences with ***It's All One***. In a study of 423 users of ***It's All One*** from around the world, respondents approved of the program promotion of gender equality and critical thinking skills. Global case studies of programs that implemented ***It's All One*** suggest that the tool is flexible enough to be used with diverse audiences (Rogow et al., 2013).

Before 2015, little evaluation data was available for ***It's All One***, but one sex education initiative has filled that gap. The Sexuality Education Initiative (SEI), launched by Planned Parenthood of Los Angeles (PPLA), sought to

equip Los Angeles high schools students with skills to manage their sexuality in a respectful, egalitarian manner. PPLA drew from the content of *It's All One* in their efforts to create an evidence-based, rights-based, gender equitable sex education initiative (Marques & Ressa, 2013).

A study of 1,447 students at 10 urban high schools gauged the effects of the SEI curriculum compared to the effects of a control sexuality education curriculum. The study found that students exposed to the SEI curriculum were more likely than those in the control group to exhibit improved knowledge about sexual health, more positive attitudes about rights in casual sexual relationships, and a stronger sense of self-efficacy to set sexual limits and handle risky situations (Rohrbach et al., 2015). SEI shows promise as a program that can instill values related to healthy sexuality.

ABSTINENCE-ONLY SEXUALITY EDUCATION

The sexuality education programs designed for children and youth discussed above consist of comprehensive sexuality education programs and sexual violence prevention programs. Abstinence-only sexuality programs targeting youth have been a source of controversy because of their content and messages regarding sexuality and sexual violence.

Some cultural attitudes and discourses may generate shame or discomfort around issues of sexual pleasure and communication. One possible result is sexuality education programs that emphasize health matters (i.e., STDs, unintended pregnancy) and consent issues (i.e., sexual coercion and pressure) but neglect pleasure and comfort with one's sexuality.

Some abstinence-only sexuality education curricula contain controversial messages about sexuality, including what constitutes healthy sexuality. SIECUS reviewed several abstinence-only sexuality education programs intended for school-age youth, including ***Aspire, Choosing the Best, Game Plan, Heritage Keepers, Worth the Wait, Why Know,*** and ***Family Accountability Communicating Teen Sexuality*** (FACTS). SIECUS claimed that many abstinence-only curricula either associated premarital sex with shame and negative consequences, or depicted sex as an negative, uncontrollable force. SIECUS also claimed that specific abstinence-only programs, such as ***Choosing the Best Way*** and the school assembly programs of Mike Long, contain content that can be construed as blaming victims of sexual assault (SIECUS, 2008).

Lamb, Graling, and Lustig (2011) reviewed four abstinence-only curricula selected from the Abstinence Clearinghouse website: ***WAIT Training, Aspire, Choosing the Best Journey,*** and ***Game Plan.*** These newer editions of abstinence-only curricula avoid some of the stereotypical pitfalls of earlier curricula, acknowledging that members of both sexes can be capable of sexual pressuring and avoiding messages that make girls "gatekeepers" of sexual purity. However, while these curricula acknowledge that sexual activity is pleasurable, ***Choosing the Best Journey*** suggests that sexual pleasure is dangerous and potentially addicting. ***Game Plan*** suggests that sexual activity is only

pleasurable and legitimate within opposite-sex marriage. *WAIT Training* and *Aspire* contain content that could be construed as victim-blaming toward sexual assault survivors. For example, *WAIT Training's* date rape handout includes a statement to females that provocative clothes are "disrespectful" to the male she is with. Also, *Aspire* looks askance at a female in a hypothetical abusive relationship because she did not have "standards" before entering the relationship (Lamb et al., 2011).

Unfortunately, there is a dearth of research on what, if any relationship exists between abstinence-only sexuality education and sexual violence prevention and risk reduction. Future quantitative and qualitative studies on sexuality education that fails to promote healthy sexuality may shed light on this area. Because some abstinence-only programs fail to promote healthy sexuality and contain problematic messages about sexual violence, it may prove fruitful to compare research on such programs to research on comprehensive sexuality programs.

DIVERSE POPULATIONS

Very little research explores the impact of sexuality education on the primary prevention and risk reduction of sexual violence among diverse populations, such as children and adolescents with disabilities, or youth who identify as LGBTQ. The small amount of relevant research, while problematic, nevertheless encourages discussion and future research about sexuality education with diverse groups.

Although more sexuality education programs are including LGBTQ-relevant content, some programs past and present fail to discuss healthy sexuality in a way that reflects LGBTQ experiences. This, in turn, may impact how LGBTQ persons understand and experience their sexuality, as well as their risk for sexual victimization.

Between February 2005 and January 2006, 499 men between the ages of 18 and 24 participated in the Healthy Young Men's (HYM) Study, a longitudinal study of men who have sex with men. Participants completed surveys every six months over the course of two years, and targeted respondents also participated in qualitative studies. According to a 2010 article on the HYM study, several respondents complained that the sexuality education they received in school contained little or no content about same-sex sexual activity or anal intercourse. Many respondents reported that they first learned about same-sex sexual activity from friends, peers, the internet, pornography, and/or "trial and error" sexual experiences with other males. For a small number of respondents, sexual initiation took place when they were minors with much older partners (namely men in their twenties or thirties), and thus such experiences would qualify as statutory rape. Additionally, a small number of respondents reported that their first experiences of anal intercourse were painful When characterized by a power imbalance

between themselves and older partners. When they asked their partners to stop or change positions during intercourse, they were ignored, which constituted rape (Kubicek, Beyer, Weiss, Iverson, & Kipke, 2010).

Because the Kubicek et al. (2010) article failed to provide percentages for respondents whose sexual initiation qualified as statutory rape or sexual assault, this material is problematic. While the article hints that a lack of LGBTQ-specific sexuality education and healthy sexuality messages may be correlated with sexual victimization, there is insufficient data to confirm this link. Nevertheless, researchers may want to explore whether or not a relationship exists between sexual violence prevention among LGBTQ persons and their exposure to LGBTQ-specific sexuality education and healthy sexuality messages.

A more recent study also found that sexual minority youth were frustrated with the dearth of sex education and healthy sexuality messages geared toward their community. During a study of school-based sexuality education experiences with 30 gay, bisexual, and questioning male youth, respondents complained that the sex education they received was heteronormative and narrow in scope. Respondents expressed a strong desire to see school-based sex education that was inclusive of LGBT persons (Pingel, Thomas, Harmell, & Bauermeister, et al., 2013).

Homeless youth represent a vulnerable population in need of sexual and reproductive health interventions, including sex education. Homeless youth who engage in high-risk sexual behavior and survival sex are at high risk for poor sexual health (Tyler, Whitbeck, Chen, & Johnson, 2007). Sizeable percentages of homeless youth experience sexual victimization while on the street, making sexual assault prevention an important priority for this population (Rabinovitz, Desai, Schneir, & Clark, 2010).

Holistic sex education interventions that promote healthy sexuality and sexual violence prevention can be carried out in clinics, shelters, and
counseling services that serve homeless youth (Tyler et al., 2007). However, research has yet to explore the relationship between sex education, healthy sexuality messages, and sexual violence prevention among homeless youth.

Children and youth with disabilities are another population whose exposure to sexuality education warrants further research. Children and adolescents with physical and developmental disabilities experience sexual victimization at higher rates than their non-disabled counterparts (Brown-Lavoie, Viecili, & Weiss, 2014; Mueller-Johnson, Eisner, & Obsuth, 2014). Interventions related to sexual abuse prevention and healthy sexuality are thus of special importance to young people with disabilities.

One Massachusetts study suggests that gaps exist in the healthy sexuality education of some people with disabilities. In a 2010 study of 42 Massachusetts service providers who offer services to people with disabilities, 71% of respondents reported that healthy sexuality and relationship training is provided to some clients. Only 7% indicated that such training was provided for all clients served by their agency. However, 65% of respondents reported that their agency lacks a policy for encouraging healthy sexuality and healthy relationships (Massachusetts Department of Developmental Services, 2011). Researchers may wish to conduct research on children and youth with disabilities to determine whether healthy sexuality training promotes risk reduction, sexual violence prevention, or attitudinal changes in this population.

Youth in the criminal justice system, youth in foster care, and youth with mental health conditions have unique sexual health needs and vulnerabilities (Gowen & Aue, 2011). Additional research is needed on what role sex education and healthy sexuality messaging plays in sexual violence prevention among these populations.

Studies have explored the efficacy of anti-sexual abuse programs in preventing sexual abuse perpetration among sexually reactive children (Duffany & Panos, 2009) and adolescent sexual offenders (Seabloom, Seabloom, Seabloom, Barron, & Hendrickson, 2003). However, little research looks at the impact of healthy sexuality messaging on sexually reactive children and juvenile sexual offenders.

Some juvenile offender treatment programs include a healthy sexuality component, in addition to components related to personal accountability. For example, an article about Child and Youth Services of Saskatoon District Health describes a treatment program for adolescent sexual offenders that incorporates healthy sexuality content. Clients participate in a 15-session psychoeducational group with two sessions devoted to healthy sexuality. The program presents sexuality as a natural and good aspect of the human experience that should be expressed in non-harmful, non-coercive ways (Perry & Ohm, 1999). Evaluations of such programs could reveal whether or not healthy sexuality initiatives reduce the risk of future sexual offending among these populations.

CONCLUSION

Insufficient published research exists to support or reject the hypothesis that healthy sexuality educational efforts are effective tools for promoting primary prevention and risk reduction of sexual abuse. The impact of healthy sexuality programming on children and adolescents is not well understood. A small number of studies suggest that some programs can be promising tools for educating children and youth about healthy sexuality, sexual abuse, and respectful sexual behavior. Future research should explore relationships between exposure to sexuality education programs with healthy sexuality content, sexual violence perpetration, sexual violence victimization, and attitudes toward sexual violence.

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