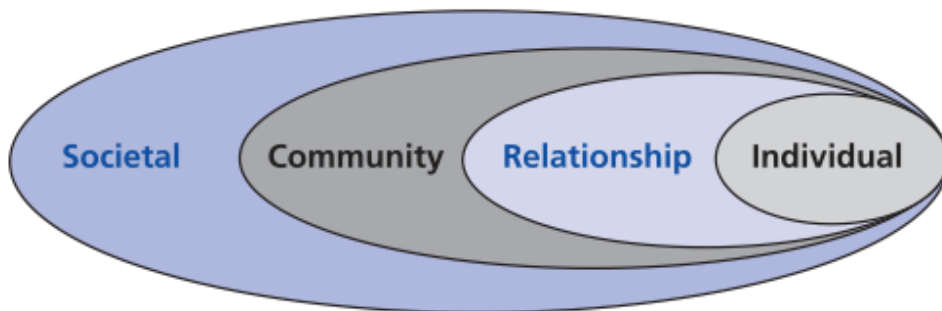


Theoretical Frameworks and Models Commonly Used in Sexuality Education Programs and Curricula: A Summary

Sexuality education programs and curricula that build on prior research and use health behavior theories are more likely to be effective. Educators use theoretical frameworks to specifically structure curricula on factors known to impact sexual behavior, known as behavioral determinants, and attempt to change these cognitive, behavioral, and psychosocial characteristics. Factors affecting sexual behaviors occur at multiple levels, including the individual, relationship (e.g. familial, romantic or friend relationships), community and societal levels. These factors can be depicted as concentric circles, and can be referred to as the social-ecological model, as shown below.



Graphic Source: <http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>

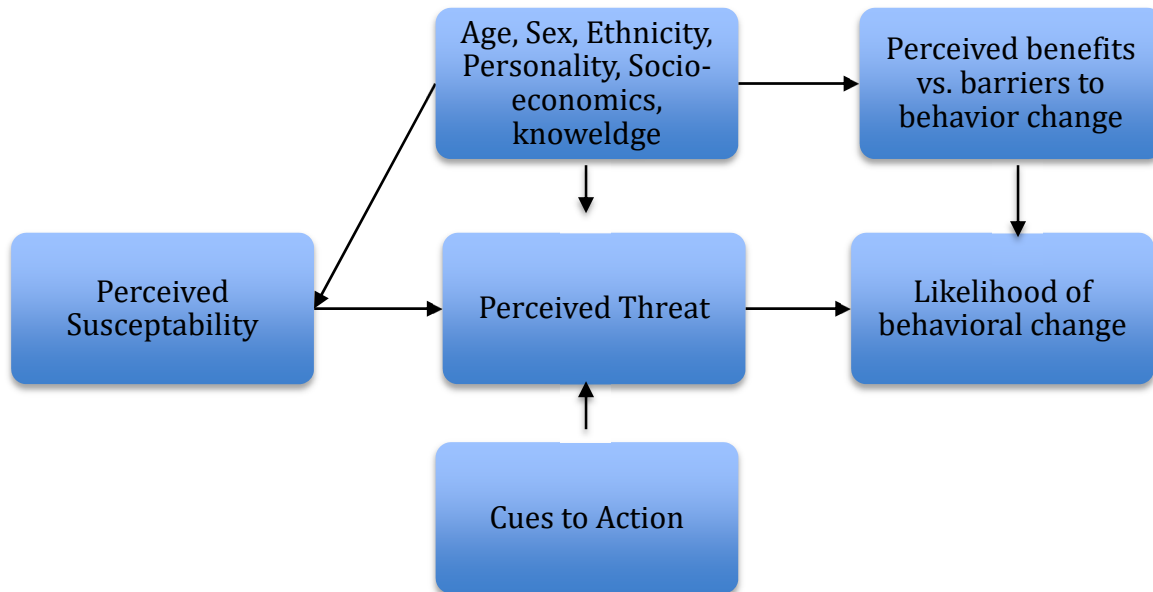
Most sexuality education curricula are focused on the individual, relationship and community levels of effects.

In addition to focusing on specific behavioral determinants these targets, educators developing or planning sexuality education curricula must also carefully consider the relationships between various factors that affect sexual behavior and the interrelationships of those factors. Theoretical frameworks provide a structure to make predictions and explain how these factors affect one another and focus attention on those that are critical to behavior change.¹ Most sexuality education curricula are focused on the individual, familial and community levels of effects and many use several theoretical assumptions. Descriptions of the most commonly used theories and models in adolescent sexuality education programs and curricula are offered below.

Health Belief Model – This model assumes that an individual’s readiness for change is based on their assessment of the threat of a health problem and the likelihood of being able to reduce that threat through personal actions. Use of the Health Belief Model focuses students’ attention on perceived susceptibility (his/her subjective perception of risk); perceived severity (feelings about the relative seriousness and consequences of the risk); perceived benefits (beliefs about the relative effectiveness of behaviors that can reduce the threat); and perceived barriers (potentially negative aspects of a protective factor or risk reduction measure).¹ This model relies on students weighing different variables before deciding on an action or behavior.

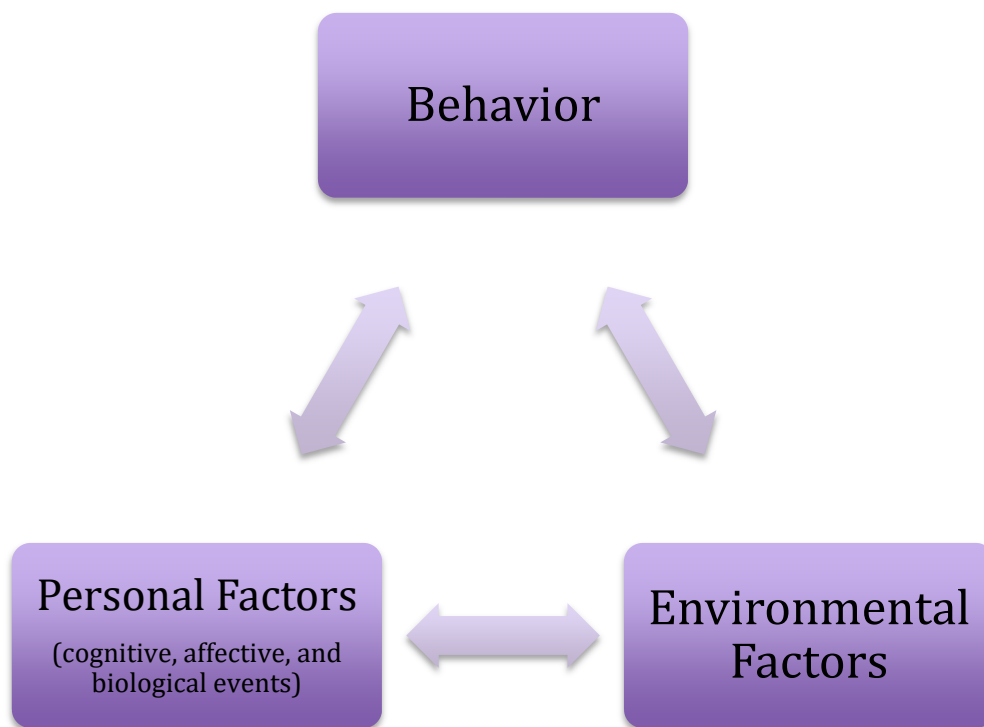
In addition to weighing one's options, students must also believe these actions or behaviors will lead to a desirable outcome and they must feel confident that they can attain this outcome in order to increase the likelihood of them adopting the behavior(s). This model emphasizes personal goals, threat assessment, self-efficacy, and decision-making skills. An example of a common sexuality education activity based on the Health Belief Model would be having students brainstorm the reasons a young person might choose to use protection during sex (perceived benefits) and the reasons they might choose not to use protection (perceived barriers).

Figure 1. Health Belief Model



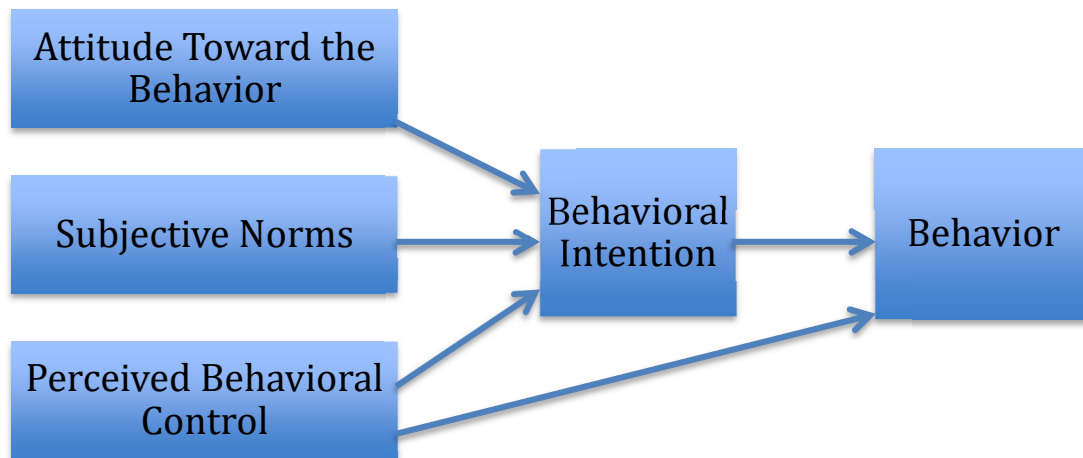
Social Cognitive Theory – This theory assumes that behavior is determined by the continual interaction between personal knowledge, skills, attitudes, interpersonal relationships, and environmental influences. Most sexuality education curricula address cognitive learning; however, knowledge alone is not sufficient to change behavior.² Sexuality education programs using social cognitive theory incorporate behavioral skills practice and positive modeling of healthy sexual behavior. Building skills through practice and modeling enables students to build self-efficacy, the belief that they can change behaviors, even when they experience challenges or barriers. An example of common sexuality education activity based on the Social Cognitive Theory is a role-play in which participants demonstrate and practice using skills to avoid and refuse pressure to have unprotected sex.

Figure 2. Social Cognitive Theory



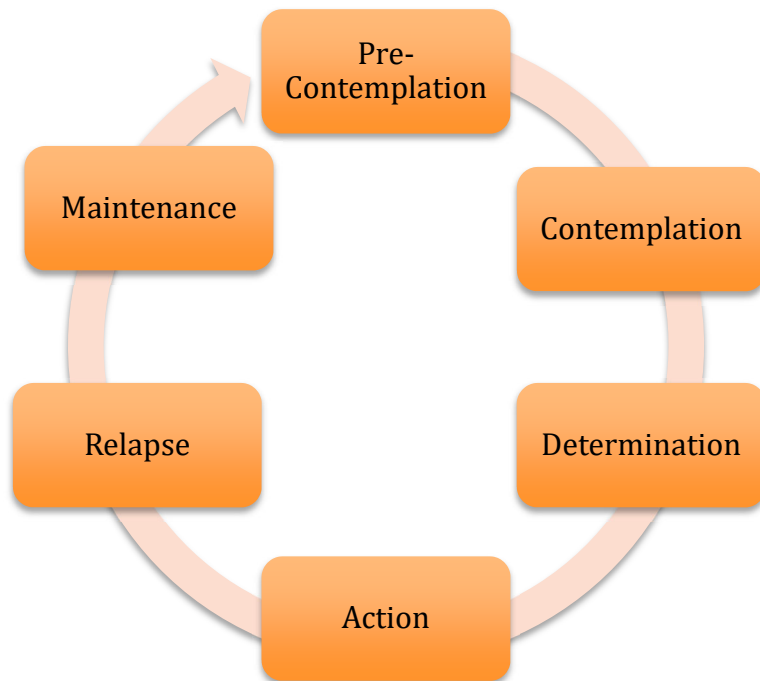
Theory of Planned Behavior – This theory assumes that behavior can be predicted by an individual’s intentions to perform a behavior based on their attitudes toward the behavior, subjective norms toward the behavior, and their perception of control over the behavior.³ The Theory of Planned Behavior is an extension of the earlier Theory of Reasoned Action. Sexuality education curricula that focus on developing positive attitudes toward healthy sexual behaviors and social acceptance for these healthy behaviors result in higher levels of intentions to use health promoting behaviors. Curricula using the Theory of Planned Behavior recognize that attitudes are affected by individuals’ beliefs concerning the possible consequences for an action or behavior while also considering the importance of the eventual outcome and address the development of these attitudes and beliefs. In addition, these curricula include strategies that encourage adolescents to analyze beliefs about what people, whom they consider to be important in their lives, think they should do (subjective norms) and their motivation to comply with these expectations. The presence of or lack of certain factors informs individuals’ decisions about perceived personal control, thus making it easier or harder to perform the behavior.³ An example of a sexuality education activity based on the Theory of Planned Behavior is to have students brainstorm factors that might negatively impact an adolescents decision not to get tested for STDs. Identify multiple strategies for removing the barrier in each situation.

Figure 3. Theory of Planned Behavior



Transtheoretical (Stages of Change) Model – This model assumes that modification of behavior involves movement through stages of change as opposed to an isolated incident. Curricula grounded in the Transtheoretical Model will guide students through five stages of change: pre-contemplation (little intention to change the behavior in the future), contemplation (intends to change the behavior within the next six months), preparation (intends to take steps to change within the next month), action (engaging in the health behavior within the last six months), and maintenance (consistent practice of the behavior over six months to five years).⁵ The Transtheoretical Model suggests that cognitive and emotional processes initiate movement from one stage to the next, primarily from pre-contemplation to contemplation. A focus on knowledge and attitudes at this point in the curriculum are effective. Skill building and behavioral processes have a greater effect on subsequent movements between stages. Previous research using the Transtheoretical Model to change health behaviors has shown that moving people from stage one toward taking action doubles the likelihood that an individual will change the behavior.⁵ Interventions should be appropriately tailored to a person’s stage with processes also relevant to that stage. Use of this model can help educators structure instructional and assessment strategies in a manner that allows students to personalize the concepts and skills. An example of sexuality education activity based on the Transtheoretical Model is to ask students to identify important qualities of a healthy relationship and examine characteristics of a good partner in a relationship. Students will then create a “relationship agreement” that describes agreements by two partners in a romantic relationship which include behaviors that the both partners as a couple agree to do and not do to maintain a healthy relationship. Students will predict situations that may interfere with these agreements and design strategies to avoid these situations or address behaviors that were not agreed upon or are unhealthy to the relationship.

Figure 4. Transtheoretical Model



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