The Gap Between Attitude And Action: A Mixed Methods Study Of Sexual Self-Stigma As A Predictor Of Consent Behavior

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The Gap between Attitude and Action
A Mixed Methods Study of Sexual Self-Stigma as a Predictor of Consent Behavior

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Abstract

Introduction: More than 1 in 3 women and 1 in 4 men will experience some type of sexual violence in their lifetimes (NISVS | CDC, 2021). While a significant body of research exists on predictors of reporting behavior after sexual assault victimization, far less research has attended to factors that may contribute to perpetration, such as sexual self-concept. The current study investigates sexual self-concept and its relationship to health behavior and notions of sexual consent in a college student sample. Methods: Quantitative and qualitative data were collected from 160 Yale undergraduates 18 years or older with approval from the Yale University IRB (66.9% female, 40.6% white, 66.3% heterosexual). Findings: Adjusted linear regression models revealed that levels of sexual self-stigma were predictive of a 2.10 and 3.86-unit increase in alcohol use disorder and sexual risk-taking scores, respectively (p<0.01). Additionally, sexual self-stigma was found to have a significant negative association with a subscale assessing perceived behavioral control (PBC; p<0.01). Finally, in a multinomial logistic regression model, a 1-unit increase in sexual self-stigma was associated with 8.78 times the odds of having low PBC and less positive attitudes compared with having high PBC and more positive attitudes (95% CI: 1.73, 44.51; p=0.008). A 1-unit increase in sexual self-stigma was also associated with 13.70 times the odds of having low PBC and less positive attitudes toward consent compared to having high PBC and less positive attitudes (95% CI: 1.75, 107.08; p=0.012). Conclusion: These findings suggest that sexual self-stigma may be an important factor to consider in the primary prevention of sexual assault, particularly as it pertains to exercising behavioral control in the context of sexual consent.
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1. Introduction

“Informed! Mutual! Enthusiastic! Ongoing!” My students chanted the words with the lukewarm enthusiasm characteristic of 20 ninth graders immediately after lunch period. We had just begun our health class unit on sexual health, beginning with a lesson on consent. The students watched a video comparing sexual consent to tea, which illuminated important features of the concept including the inability of unconscious people to consent, the necessity of obtaining consent again before every sexual activity, and the idea that people are entitled to define and redefine their boundaries at any point during a sexual encounter. I felt like the lesson was going well, and my colorful slides listing easy-to-recall adjectives describing healthy consent were going off without a hitch. After breaking into small groups to run through scenarios, however, I was confronted with how far from straightforward this concept was. As I listened to them practicing saying no or communicating what their boundaries were, what I heard was a chorus of robotic voices, standing stiffly across from each other, reading words from a page. Curious about what I was seeing, I began stopping at each group and asking them how it was going. I got a few murmured “fines” and “okays” until I got to a table toward the back of the room. A student looked me directly in the eye and said, “Hannah, I totally get that this is important, but I just wouldn’t say this.”

*I just wouldn’t say this.* With one phrase, my student had brought my perfectly crafted lesson plan crumbling to the ground. But she had also provided a more honest, accurate appraisal of the complexity inherent to consent than I had dared. I stopped the lesson and opened up the floor for discussion: “Why wouldn’t you say these things in real life?,” I asked. I was humbled and grateful for their honesty. Responses ranged from “I feel
like someone might not like me as much if I say no” to “I don’t want to make such a big deal out of this” to “I don’t know.” What they touched on was a fundamental disconnect between what we should do - what is right and important - and what we actually do. That discussion was enlightening, but it produced far more questions than answers. This study is an attempt to answer just a few of them in the context of a university population.

At the current rate, more than 1 in 3 women and 1 in 4 men will experience some type of sexual violence in their lifetimes. Narrowed just to rape and attempted rape, still nearly 1 in 5 women and 1 in 38 men will be affected (NISVS | CDC, 2021). Zero in even further to college and university campuses, and results of the 2019 Association of American Universities (AAU) study estimated that 13% of students had experienced nonconsensual sexual contact, a 3% increase from 2015. While the precise nature of this problem, as well as its specific consequences for health and wellbeing, will be discussed at length in the following section, let us begin by acknowledging that sexual assault¹ is a serious and pervasive problem (Cantor et al., n.d.).

1.1 Historical Context

Although it has certainly gained more attention in recent years, sexual assault is not a new problem, particularly not on college campuses. Colleges and universities were reckoning with sexual assault in significant and concrete ways beginning in the early 1990s. The Jeanne

¹Sexual assault is defined here as nonconsensual sexual behaviors and contact including rape, attempted rape, unwanted sexual touching, and forced performance of sexual acts (RAINN, 2021).
Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act, better known as simply the Clery Act, was passed in 1990 and mandated the timely disclosure of threats to public safety by colleges and universities (RAINN, 2021) As part of this act, schools were required to report crimes, including sexual violence, and to maintain public records and statistics of these crimes. The Clery Act was intended to raise awareness about the issue of sexual assault, but has notably been criticized in more recent years for the role it plays in decentering the needs of survivors and taking a punitive, conservative stance toward sexual violence, at odds with its progressive feminist roots (Anderson, 2016; Kulbaga & Spencer, 2019). Nonetheless, the Clery Act did a lot to raise the profile of both sexual assault as well as the role of colleges in its prevention. Title IX - legislation that prohibits discrimination on the basis of sex in those educational programs and activities that receive any type of federal funding - had long been existence by this point, having been passed in 1972, but came into the spotlight once again alongside conversations about campus sexual violence and the role of educational institutions (DOJ, 2015).

After the 1990s, the US experienced a long period of relative quiet on the subject of campus sexual assault, but significant renewed attention was paid to this landmark legislation in 2011 with the “Dear Colleague” letter, issued by the Office for Civil Rights under the Obama administration (“Opinion | The Path to Obama’s ‘Dear Colleague’ Letter,” n.d.). Although the letter was ultimately rescinded in 2017, it nonetheless brought sexual assault to the forefront of public consciousness (Russlynn, 2011). Adding to that pressure was the It’s On Us social campaign. In 2014 the Obama administration, at the recommendation of the White House Task Force to Prevent Sexual Assault, founded It’s On Us: an initiative
aimed at better preventing sexual assault (It’s On Us / Our Story, n.d.). The #MeToo social media movement also came hot on the tail of It’s On Us, with viral social media posts publicizing allegations of sexual abuse and assault. Although the movement originally began in 2006 with founder Tarana Burke, it gained worldwide attention in 2017 with a viral tweet by actress Alyssa Milano alleging sexual assault by Harvey Weinstein (“Me Too Founder Tarana Burke,” 2020). Together these movements raised the profile of the issue of sexual assault and demanded action, particularly from academic institutions, who had, and continue to have, disproportionately high rates of sexual assault compared with the general population (RAINN, 2021). The ways in which colleges and universities have gone about addressing sexual assault will be discussed in a subsequent section.

1.2 Review of Existing Research

Beyond the obvious issue of its continued prevalence, sexual assault results in a myriad of serious health consequences. Physical health outcomes can include genital injury, heightened HIV risk, and unwanted pregnancy, which presents a physical, psychological, and financial burden on the victim (Stockman et al., 2013; Teerapong et al., 2009). Beyond these physical consequences, victims of sexual violence can also suffer from mental health problems, including posttraumatic stress disorder (PTSD), depression, psychosis, and substance abuse (Oram, 2019). Those who have experienced sexual violence have also been shown to be at heightened risk of suicide (Mason & Lodrick, 2013). Sexual violence victims also frequently experience interpersonal challenges after being assaulted, such as difficulty
re-engaging in intimate relationships and sexual activity as well as increased risky sexual behavior (Kaufman et al., 2019; Mason & Lodrick, 2013).

In light of the significant health consequences posed by sexual assault, researchers have naturally shifted to thinking about prevention. A large body of existing research focuses on secondary or tertiary prevention of sexual assault. This involves identifying predictors of various outcomes after sexual violence has taken place and intervening to prevent re-victimization and reduce the short and long-term negative health impacts of sexual assault on victims. One area of particular focus in this body of research is rape myth acceptance (RMA). Rape Myth Acceptance (RMA) is the endorsement of beliefs that trivialize sexual assault, exonerate the perpetrator, and blame the victim (Burt, 1980). Barbara Burt derived the concept of RMA from social psychology and feminist theory and found that attitudes including the embrace of rigid gender roles, sexual conservatism, and other demographic factors were highly predictive of this construct. This phenomenon was the foundation of the Illinois Rape Myth Acceptance (IRMA) scale, and myths measured by the tool include “she asked for it,” “it wasn’t really rape,” “she lied,” and “he didn’t really mean to” (Payne et al., 1999).

RMA serves an adverse role for both perpetrator and victim. For a perpetrator of sexual assault, endorsing rape myths may convince them that their actions are not inappropriate and do not constitute assault. For a victim, RMA may cause a victim to think they are responsible for having caused their assault or convince them that what happened was not serious or was not assault at all (Burt, 1980). Research has linked RMA to several outcomes with serious consequences for secondary prevention. For example, a study in South
Africa found that negative attitudes toward women, as measured by level of RMA, were associated with higher levels of HIV risk behavior (Kaufman et al., 2019).

Another serious consequence of RMA is that it has been shown to present a barrier to sexual assault reporting. Research has shown that fear of retaliation, worry about not being believed, concern over culpability, and belief that assault is trivial were frequently reported reasons for refraining from disclosing an assault (RAINN, 2021). These reasons clearly reflect rape myths, such as victim responsibility and triviality of assault. Heath et al (2013) found that among a sample of incarcerated women, the acceptance of rape myths was directly associated with the likelihood of reporting assault (Heath et al., 2013). This is problematic for secondary prevention because not reporting can pose significant barriers to recovery and posttraumatic growth after sexual assault. Broman-Fulks and colleagues (2007) found that disclosure of assault within one month of the event significantly reduced major depressive episodes among youth. Dworkin and colleagues (2018) also found that higher school level-mean rape myth acceptance (RMA) measures were associated with increased depressive symptoms and alcohol use among adolescents who had experienced sexual assault.

There is considerably less research relating to the primary prevention of sexual assault perpetration, in large part because identifying predictors of perpetration is extremely challenging. Social desirability bias may prevent people from disclosing perpetration and rape myths may also prevent the acknowledgment of this behavior as rape at all. A 2006 study by Kolivas and Gross called attention to this issue, reporting that despite the very high sexual victimization rates reported by women using the Sexual Experiences Survey (SES), a
common tool for measuring sexual assault victimization, the version of the SES used to
measure perpetration recorded far lower rates of perpetration at odds with this high
victimization rate (Kolivas & Gross, 2007). In general, those responding to SES perpetration
items tend to report rates of perpetration that are a fraction of the reported rates of
victimization. It is important to note that this research is subject to several limitations, a
major one being that in many studies mentioned, the SES for victimization is used amongst
only women and the SES for perpetration is used amongst only men. However, despite this
limitation, the authors present a compelling body of research suggesting that either very few
men are responsible for the victimization of many women, men’s reports are significantly
biased, or both. Resultantly, due to this clear issue of validity in perpetration data, research
into predictors of perpetration is sparse.

Some research does show that RMA is also predictive of perpetration. A 2021
meta-analysis identified 28 studies on the subject, and random-effect analysis identified a
moderate relationship between sexual coercion perpetration and RMA across gender and
time (Trottier et al., 2021). Other studies have found that both the individual acceptance of
rape myth as well as perceived peer RMA to be associated with subsequent sexual and dating
violence perpetration (Collibee et al., 2021; Mouilso & Calhoun, 2013; Shafer et al., 2018).
However, other studies have produced more mixed results. For example, a 2005 study of
predictors of sexual assault perpetration found that after accounting for previous
perpetration RMA was no longer a significant predictor (Loh et al., 2005). Some researchers
have even suggested that RMA may arise after perpetration as a means for justifying actions
and alleviating guilt (Maruna & Mann, 2006). A 2018 systematic review of literature on the
relationship between RMA and sexual violence perpetration highlighted the difficulty in establishing a temporal relationship between RMA and perpetration due to the nature of the available data which is primarily cross-sectional, as well as the validity of the RMA construct itself (Yapp & Quayle, 2018).

Perhaps as a result of the conflicting findings around RMA as a predictor of perpetration, some researchers have shifted focus to early childhood factors, such as bullying and family-level factors. Several studies have specifically identified middle school bullying as a predictor of sexual violence perpetration later in adolescence and into adulthood (Chen & Foshee, 2015; Espelage et al., 2012; Falb et al., 2011). Homophobic name-calling by middle school students, in particular, was associated with increased odds of perpetrating sexual violence in high school—a significant trend considering the disproportionate number of victimizations experienced by sexual and gender minority youth (Espelage et al., 2018; E. Miller et al., 2018). Other research has connected adverse childhood experiences and negative school experiences, including difficulty in school and involvement with antisocial peers, to sexual violence perpetration in adolescence and young adulthood (Casey et al., 2017; Froidevaux et al., 2020; E. Miller et al., 2018; Schnurr & Lohman, 2013). Similar factors—specifically exposure to family conflict, low connectedness to parents and teachers, social isolation from peers, and academic difficulty—have also been identified as risk factors for perpetrating bullying (Elsaesser et al., 2013; Herrenkohl et al., 2012; Nansel et al., 2001; Taliaferro et al., 2020). Given the research suggesting a connection between bullying and sexual violence perpetration, these factors are important to consider as potential precursors to sexual violence as well.
1.3 Prevention

Some of the research on these predictors has begun to inform primary prevention programming and interventions. Social-emotional learning programs intended to build interpersonal skills, empathy, and decision-making capacity among children have shown promise as early interventions in the prevention of sexual violence (Caldarella et al., 2009; Espelage et al., 2013). Comprehensive sex education with a social-emotional learning component has also been shown across multiple studies to improve social, emotional, and communication skills, as well as reduce homophobia, bullying, and dating and intimate partner violence perpetration and victimization (Goldfarb & Lieberman, 2021).

Despite these promising examples of translational research, however, the relative lack of research in the area of primary sexual assault prevention has been extremely limiting in developing evidence-based prevention programs. While consent education has become a central component of many such programs, particularly on college and university campuses, our lack of understanding of how people conceptualize sexual consent and those factors that influence these conceptualizations are understudied. One such factor that has gained some attention in recent years is sexual self-concept.

1.4 Sexual Self-Concept

Sexual self-concept is the extent to which someone understands their own physical, emotional, mental, and social well-being in relation to sexuality. This includes positive attitudes toward one’s own sexuality, sexual relationships, and one’s body as well as the possibility of pleasurable, consensual, non-violent, non-discriminatory, and safe sexual
experiences (W. M. Edwards & Coleman, 2004). Sexual self-concept has garnered more attention in recent years as it has been linked to multiple different health outcomes and behaviors. Research has shown that various aspects of sexual self-concept, such as sexual satisfaction and assertiveness, have been associated with risky sexual behavior (Breakwell & Millward, 1997; Rudolph et al., 2020). Other research has shown self-esteem and self-concept to be associated with sexual health information-seeking behavior (McKellar et al., 2017). Extensive research has focused on the implications of sexual self-concept on the mental health of those living with infertility, disability, or chronic conditions (Alariny et al., 2019; Rathore et al., 2019; Wischmann et al., 2014). These initial findings suggest that sexual self-concept may play an integral role in the ways in which people think and behave in relation to sexual activity, including the development of notions of consent and healthy relationships. Despite its clear relevance to sexual behavior and decision-making, however, there is currently no research on the relationship between sexual self-concept and consent. This study is an attempt to fill that gap in the literature.

1.5 Current Study

The current study aims to elucidate factors related to the development of sexual self-concept, as well as how sexual self-concept relates to sexual health and behavior. Of particular interest is how sexual self-concept relates to understandings and behavior around consent.

I hypothesize that factors relating to early childhood development impact the development of sexual self-concept, as measured by the Sexual Self-Stigma scale. These
factors include family dynamics and sexual and reproductive health knowledge. I hypothesize that self-stigma in turn impacts risky behavior including alcohol use and sexual decision-making. I further hypothesize that sexual self-stigma influences notions of consent, including both attitudes and behavior. I hypothesize that self-stigma has a particularly strong association with behavioral control as it pertains to sexual consent. Qualitative data examining participants’ self-defined understandings of consent, environments in which they prefer to have conversations about sex and consent, and general perceived gaps in knowledge and understanding around these topics will provide information about the development of notions of consent in the study sample.

2. Methods

2.1 Theoretical Framework

The methods employed in this study rely heavily upon the Theory of Planned Behavior as a theoretical framework for understanding behavior change. The Theory of Planned Behavior, an iteration of the 1980 Theory of Planned Action, posits that the likelihood that an individual will engage in a behavior depends on the individual’s intention and behavioral control (Ajzen, 1985). The theory assumes that behavioral control on an individual level is comprised of attitudes, behavioral intention, subjective norms, social norms, perceived power, and perceived behavioral control (Figure 1). The theory is particularly useful for behaviors over which individuals are capable of exerting self-control and lends itself well to the study of sexual behaviors. It has been successfully applied to
predict behavior in the context of intimate partner violence and sexual offending by interrogating the subjective norms, attitudes, and intentions that inform sexual behavior (K. M. Edwards et al., 2015; D. L. Miller, 2010).

Using this framework as a basis, this study attempts to examine attitudes and perceived control over behavior relating to sexual consent. Given the initial findings on the potentially important role of sexual self-concept in recent years, this will be a primary factor of interest.

**Figure 1**

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**2.2 Procedure**

From December 2021 to March 2022 an observational, web-based survey using the Qualtrics platform was conducted at Yale University after approval by the Yale University Institutional Review Board. Eligible participants were those 18 years of age or older who were currently enrolled as undergraduate students at Yale College. Quantitative data was collected.
through a series of validated survey measures as well as original survey items. Additionally, several qualitative questions at the end of the survey offered participants the opportunity for further elaboration on several of the topics covered in the survey.

Two methods of recruitment were employed. First, the survey was accepted to the Yale Intro to Psychology Subject Pool: a forum for students currently taking the introductory psychology course to receive course credit for participating in various surveys and experiments. Approximately 130 participants were recruited through this venue. Second, the survey was distributed to the wider Yale College student body through on-campus recruitment, and these students were eligible to be entered into a lottery for one of five $100 gift cards. Flyers were posted on bulletin boards around campus and distributed in libraries and other common areas advertising the study and providing a link for students to participate. Additionally, 135 emails containing information about the study as well as an electronic copy of the flyer and survey link were emailed to representatives for every Yale College student group for which there was a listed address on the Campus Connect database. Approximately 40 students were recruited through this method.

### 2.3 Measures

**Demographics**

Data was collected on the demographic characteristics of the study population including factors relevant to the university setting, such as whether students were on financial aid. Other data collected included age, race, gender identity, sexual orientation, and childhood household income.
Sexual Consent

The Sexual Consent Scale (SCS) assessed participant perceptions of consent through the use of five subscales: (Lack of) perceived behavioral control, Positive attitude toward establishing consent, Indirect behavioral approach to consent, Sexual consent norms, and Awareness and discussion (Humphreys & Brousseau, 2009). Responses were on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). The theoretical foundation of the SCS is the Theory of Planned Behavior, and the included subscales are intended to measure relevant constructs relating to consent behavior including attitude toward the behavior, subjective norms, and perceived behavioral control.

Sexual Self-Stigma

The Sexual Self-Stigma scale assessed negative sexual self-concept². It assessed attitudes toward aspects of sexuality with which participants might associate feelings of shame, anxiety, or stigma including the self as a sexual being, thinking about sex, talking about sex, feeling sexual desire, pleasure, sexual activity, masturbation, sexual choices, sexual history, and sexual identity. It included items such as When I think about sex, I feel ashamed and If others knew my sexual history, they would think less of me. Participants responded to 13 statements on a 4-point Likert scale from “strongly agree” to “strongly disagree.” This scale

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² Drawing from the WHO definition of sexual health, sexual self-concept was broadly defined as the extent to which someone understands their own physical, emotional, mental, and social well-being in relation to sexuality including positive attitudes toward one’s own sexuality, sexual relationships, and one’s body as well as the possibility of pleasurable, consensual, non-violent, non-discriminatory, and safe sexual experiences (WHO, 2021t)
was developed, pilot tested, and validated by the primary investigator and 3 other Yale MPH students.

**Sexual Education**

A series of novel questions assessed common sources of participant knowledge about reproduction, condoms, contraceptives, STDs, healthy relationships, and consent. Source options included family members, friends, partners, healthcare providers, magazines, pornography, tv shows and movies, the internet, and sex education classes. The questions assessed the extent to which participants found these different sources impactful and trustworthy on a 4-point Likert scale.

**Health Knowledge**

Items assessing knowledge of sexual health and reproduction were adapted from the Sexual and Reproductive Health Knowledge Scale (Rahimi-Naghani et al., 2016). Ten True/False items assessed participant knowledge of pregnancy, STDs, contraceptives, and masturbation.

**Family Cohesion**

The Cohesion Subscale of the Brief Family Relationship Scale assessed participants’ perceptions of family cohesion and support using a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree) (Fok et al., 2014). Examples of items include *In our family there is a feeling of togetherness, In our family we really help and support each other, and In our family we really get along well with each other.*
Alcohol Use Disorder

The Alcohol Use Disorders Identification Test (AUDIT) 3-item measure was employed to assess problem drinking among participants (Bush et al., 1998). Participants were asked:

*How often do you have a drink containing alcohol? How many standard drinks containing alcohol do you have on a typical day when drinking? and How often do you have six or more drinks on one occasion? Responding responses were a series of numeric or temporal ranges appropriate to each question. Responses were on a Likert scale and were scored from zero to four. The scale score was computed as a total score with the highest possible score being 12.

Health Risk Behavior

Five items were adapted from the original 23-item Sexual Risk Survey developed and validated by Turchik and Garske (2010). The items assessed the frequency of certain high-risk sexual behaviors including unprotected intercourse and intercourse under the influence of drugs or alcohol (Turchik & Garske, 2010). Responses were on a 5-point Likert scale from “never” to “very often.”

Qualitative

Participants responded to several open-ended questions asking them to define consent, elaborate on their most impactful sources of information about sex and relationships, comment on environments conducive to conversations about sex, and reflect on areas of weakness in their past sexual education.
2.4 Data Analysis

Analyses for quantitative data were performed using SPSS Statistics Software version 28 (IBM, 2021). Descriptive statistics were generated for demographic information, with means and standard deviations for continuous variables and frequencies for categorical variables. Bivariate relationships among study variables of interest were assessed using a Pearson’s correlation matrix. An independent-samples t-test and one-way analysis of variance were employed to determine whether Sexual Consent Survey and Sexual Self-Stigma scale scores differed significantly by race or gender. Linear regression models were performed with variables of interest in relation to sexual self-stigma as both a dependent and independent variable. Multinomial logistic regression was performed with self-stigma as an independent variable and pairings of high and low consent scores on two subscales - (Lack of) perceived behavioral control and Attitudes toward establishing consent - as a categorical dependent variable. These scales were chosen due to their relevance in the context of the Theory of Planned Behavior (TPB). According to the TPB, attitudes and perceived behavioral control are fundamental components of an individual’s intention to engage in a particular behavior, which is in turn a determinant of actual behavior (Ajzen, 1985). High scores on the (Lack of) perceived behavioral control were interpreted as representing low perceived behavioral control, and low scores were interpreted as high perceived control. High scores on the Attitudes toward establishing consent subscale were interpreted as more positive attitudes toward consent, whereas low scores were interpreted as more negative attitudes toward establishing consent.
Sources of sexual education were analyzed descriptively to determine the proportion of participants who described receiving some or a lot of their information about reproduction, condoms, STDs, healthy relationships, and consent. A Wilcoxon Signed Rank test was run to determine whether the proportion of participants receiving information from a particular source varied significantly by subject.

Qualitative analyses were conducted with the primary investigator and one additional coder, both public health masters students, using grounded theory. Grounded theory is an iterative process for examining qualitative data to produce inductive analytic concepts (Hennink et al., 2011). By repeating the tasks of codebook development, inter-coder discussion, and memoing throughout the process, we used the qualitative responses to develop explanatory frameworks and theory.

After an initial read through all of the qualitative responses, the coding team met to define inductive codes. This formed the basis of the initial codebook. Coders then independently coded an initial round of 20 responses for each of three questions, noting any necessary changes to the inductive codes. After achieving a high degree of inter-coder agreement (>95%), the coding team met a second time to update the codebook and refine the definitions of each code. The coders then finished analyzing the remainder of the data, noting any emerging themes. Coders met to review the coded responses, and all discrepancies were resolved through discussion. Themes cutting across multiple codes were discussed and categorized during a final team meeting.
3. Results

3.1 Descriptive Statistics and Bivariate Analyses

A total of 160 participants provided complete data on study variables and comprised the analytic sample. Table 1 (Appendix A) shows descriptive statistics of the sample. The majority of the sample identified as cis-gender female (66.9%) and participants ranged in age from 18 to 23 years old, with a mean age of 19.7 (SD=1.3). The majority of participants were white (40.6%), followed by Asian (21.9%), non-Hispanic Black (14.4%), and Hispanic (13.1%). Most participants identified as heterosexual (66.3%) and most were on financial aid (62.5%). Roughly half of participants had a household income of $100,000 or more while they were growing up. According to the university, the Yale undergraduate student body is 50.1% female. Only university-wide statistics were available for race/ethnicity, but according to that data the student body is majority white (49.6%), followed by Asian (20.8%), Hispanic (13.5%), and Black (8.4%). In the 2017-18 school year, the university reported that 64% of students received financial aid of some kind (Yale University, 2021). This sample, therefore, appears to be comprised of more female students than the student body. The sample is slightly more racially diverse than the entire student body, and the number of students reporting receiving financial aid appears to be similar to the proportion of the entire student body.

The means and standard deviations for the Sexual Consent Survey scale and each subscale can be found in Table 2 (Appendix A). The highest mean subscale scores were for Positive attitude toward establishing consent and Awareness and discussion and the lowest
was for (Lack of) perceived behavioral control. An independent-samples \( t \)-test comparing mean SCS scale scores between male and female participants determined that the mean score did not differ significantly by gender (\( p=0.60 \)). A one-way analysis of variance (ANOVA) comparing mean consent scores between racial categories determined that scores also did not differ significantly by race (\( p=0.61 \)).

Of the 138 people in the sample with sufficient data for the Sexual Self-Stigma scale, the mean score in this sample was 1.83 (SD=0.30) out of a maximum possible score of 4. An independent-samples \( t \)-test determined that stigma did not differ significantly by gender in this sample (\( p=0.85 \)). A one-way ANOVA comparing stigma between racial categories also found that stigma scores did not vary significantly by race (\( p=0.85 \)).

Table 3 (Appendix A) shows the results of bivariate analyses of the study variables using Pearson’s correlation. Of the demographic characteristics, lower family cohesion was significantly associated with having a household income of less than $50,000. Being female was also associated with higher sexual self-stigma. All of the consent subscales were correlated with the overall scale except Positive attitudes toward establishing consent. The Positive attitudes subscale was negatively correlated with all of the other subscales except for awareness, with which it had a significant positive correlation.

### 3.2 Sources of Sex Education

Figures 2-6 (Appendix B) show the proportion of participants who described gleaning knowledge about topics related to sexual health and relationships on a scale of “nothing at all” to “a lot.” On the subject of reproduction, the largest proportion of participants said they
received a lot or some information from the sex education classes, the internet, TV shows and movies, and their friends. A similar distribution was observed for information about condoms, although with fewer participants reporting they had received some or a lot of information from TV shows and movies. Many participants reported getting some or a lot of their information about STDs from sex education classes and the internet, while many participants reported receiving little or no information about STDs from pornography, magazines, partners, and relatives. For information about both healthy relationships and consent, the largest proportions of participants reported having received information from the internet, TV shows and movies, partners, friends, and family members. One notable difference was that many more participants reported having received some or a lot of information about consent from sex education classes, while far fewer reported this for information about healthy relationships. A Wilcoxon Signed Ranked test revealed a test statistic of 73.50 which indicated that this difference was statistically significant (p<0.001). Conversely, a larger proportion of participants reported having received some or a lot of information about healthy relationships from their parents than did information about consent.

3.3 Linear Regression Analysis

Several linear regression models were fit to assess trends between study variables of interest. A linear regression model of the Alcohol Use Disorders Identification Test (AUDIT) scores as a continuous function of sexual self-stigma was fit to assess linear trends. According to this model, there was a statistically significant relationship between sexual self-stigma and
alcohol use disorder. After adjusting for age, gender, sexual orientation, race, income, and financial aid status, a 1 unit increase in mean sexual self-stigma score was associated with a 2.10 unit increase in total AUDIT score (p=0.006).

Another model was fit to examine the relationship between sexual self-stigma and risky sexual behavior, as measured by the Sexual Risk Survey. After adjusting for covariates, a 1 unit increase in mean sexual self-stigma score was associated with a 3.86 unit increase in total Sexual Risk Survey score, indicating that increased self-stigma is associated with increased risky sexual behavior in this sample (p=0.002).

To examine potential predictors of self-stigma, two linear regression models were fit examining the relationship between family cohesion and sexual and reproductive health knowledge with levels of sexual self-stigma as the dependent variable. A linear regression model of sexual self-stigma as a continuous function of family cohesion showed that a 1-unit increased in family cohesion was associated with a 0.003 unit increase in self-stigma but this result was not statistically significant (p=0.386). Similarly, a linear regression model examining sexual and reproductive health knowledge as a predictor of sexual self-stigma found that a 1-unit increase in health knowledge was associated with a .010 unit increase in self-stigma, but this result was also not statistically significant (p=0.742).

Based upon the Theory of Planned Behavior framework, two subscales of interest with regard to behavior around consent were the (Lack of) perceived behavioral control and Attitudes toward establishing consent subscales of the Sexual Consent Scale (SCS). An unadjusted linear regression model of SCS mean scores as a continuous function of sexual self-stigma found that a 1 unit increase in sexual self-stigma was associated with a .002
decrease in SCS, but this association was not significant at the .05 level (p=0.984). Similarly, sexual self-stigma was associated with a .217 decrease in mean *Attitudes toward establishing consent* subscale score, but this association was also not significant (p=0.286). In contrast, a linear regression model of mean *(Lack of) perceived behavioral control* subscale score as a continuous function of self-stigma detected a significant positive association, which remained significant after adjusting for age, gender, sexual orientation, race, income, and financial aid status. A 1 unit increase in sexual self-stigma was found to be associated with a 0.54 unit increase in lack of perceived behavioral control in establishing consent (p=0.006). In other words, an increase in self-stigma was associated with lower perceived behavioral control.

### 3.4 Multinomial Logistic Regression Analysis

A multinomial logistic regression model was fit to examine pairings of high and low perceived behavioral control (PBC) and attitudes toward establishing consent in this sample. The model compared the likelihood of high-high, high-low, low-high, and low-low pairings as a function of sexual self-stigma. Four models were run with each of the pairings as the reference group, and the results can be found in Table 4. In Model 4, results showed that a 1-unit increase in sexual self-stigma was associated with 8.78 times the odds of having low PBC and less positive attitudes compared with having high PBC and more positive attitudes (95% CI: 1.73,44.51; p=0.008). Also in Model 2, the results showed that a 1-unit increase in sexual self-stigma was associated with 13.70 times the odds of having low PBC and less
positive attitudes toward consent compared to having high PBC and more positive attitudes in this sample (95% CI: 1.75, 107.08; p=0.012).

3.5 Qualitative Analysis

Codes developed for each of the three questions analyzed by coders can be found in Appendix C. After achieving a high degree of inter-coder agreement, coders met to conduct thematic content analysis.

Consent

When asked to define consent, a high degree of consistency in the responses suggested common background education and awareness of this concept. More than 22% of respondents provided definitions that hit upon each of the concepts of enthusiasm, clarity, continuity, affirmativeness, and mutuality. Further, over 80% described consent as some sort of verbal agreement. Some participants also commented that consent can also be nonverbal in certain situations. One theme that emerged from grounded theory analysis was mutuality. Many participants endorsed a definition of consent that involved a two-way conversation, in which all parties express their desire to engage in a particular sexual activity.

Consent is when all parties involved in a sexual act have (enthusiastically) agreed to take part in that act based on certain terms.

Enthusiastic agreement was echoed in another theme of active consent. Some participants emphasized that consent should be enthusiastic or otherwise active, rather than a passive provision of permission or agreement. They described consent as something that should be
actively given and sought throughout a sexual encounter. The word “enthusiastic” appeared frequently in responses.

*Active, enthusiastic “yes” from both parties in a sexual encounter*

Other participants emphasized that this active consent should be sought and received repeatedly throughout sexual encounters.

*Verbal yes in response to explicitly being asked if they are okay with specific acts that are about to occur, and continued checking in throughout the encounter.*

The themes of mutuality and active consent were somewhat at odds with another theme that emerged of **permissive consent**. Some described consent as a seeking of permission that was unidirectional, with one person agreeing to do something that someone else wants to do. Participants used phrases such as “consent given to someone to perform sexual activities” and “permission to do sexual actions.” One participant laid this notion out very specifically:

*Communication, from person A, to person B about whether person A will engage in sexual activity with person B.*

Another theme that emerged in definitions of consent was that consent should be **unambiguous**. Some people expressed that consent should be clear, and that any confusion should be equated with a lack of consent.

*Sexual consent is the clear, enthusiastic, solidified agreement to known and understood and agreed upon sexual activity.*

Many also emphasized that the clarity of consent should extend to the specific acts being agreed to:
Clear, continuous, unambiguous verbal AND nonverbal indicating enthusiasm for participating in a specific sexual act.

Lastly, a theme emerged in which consent should be freely given. Consent that was not coerced was valued by some people, and some expressed that it was important to consider whether everyone was capable of giving consent, and whether they were very clear on what specifically they were consenting to.

When all parties are sober, risk aware, and willing.

Environments

When asked about which environments made participants feel most comfortable having conversations about sex and relationships, codes including privacy, familiarity, and connectedness were applied most frequently to the responses. One major theme that emerged was the importance of the physical space in which conversations took place. Physical spaces played an important role in making people feel more comfortable having conversations about sex and relationships. Spaces that are quiet and private made people feel calmer and more relaxed when having those conversations. Spaces and environments that promoted anonymity or confidentiality were also valued.

A private environment, where nobody is being patronizing and it is a clear, fair discussion.

These physical environments seemed to promote some of the feelings that came up in other themes as well. For example, familiarity and closeness with the other people in the conversation was important. Conversations about sex and relationships were easier to have
within familiar relationships, and relationships characterized by closeness or intimacy seemed to facilitate these conversations.

*Private and intimate. I only like to discuss it in very small groups and preferably only with sexual partners.*

Pre-existing relationships seemed to promote feelings of familiarity for many participants.

*Conversations with people whom I already have a relationship with or trust my anonymity and their knowledge*

Similarly, speaking with those who had **shared experience** was another theme among responses about environments that were conducive to conversations about sex and relationships. Being able to speak with those you feel have a similar background and who have relevant experiences with sex and relationships made people feel more comfortable and open to sharing.

*When the conversation is with someone who has had sexual experiences themselves and could understand.*

Another key theme among responses was descriptions of environments that were **free of judgment**. Feeling as though one would not be judged or shamed for asking questions or talking about sensitive issues was important to encouraging discussion about sex and relationships. Sex positivity made people feel more open to sharing.

*Environments in which people participating in the conversation are non-judgmental, open-minded, and respectful to one another.*

*One-on-one conversations where the parties don't feel time-constraints, stress of being overheard or judged. A place when and where parties can feel like they are
being listened to with thoughtful consideration and where questions are ok being asked.

A final theme that emerged regarding these environments was a desire for distance from the subject matter. Sex and relationships can be sensitive topics to discuss and can make people feel uncomfortable, and some participants expressed a desire for approaching these conversations from an educational perspective in a workshop or medical environment. This seemed to be related to a desire for a more structured approach to conversations.

One where’s there’s a mediator who leads the conversation and is confident talking about this topic because they have done so before.

“What I Wish I Had Known”

Participants were asked about what they wish they had known before engaging in sexual activity for the first time, and responses shed light on potential gaps in knowledge, understanding, and perspective. One theme was that participants felt they had a lack of physical health knowledge. People felt they lacked basic knowledge about biological aspects of sex, such as STDs, contraceptives, and anatomy. They expressed that they were not entirely prepared for the pain they experienced during initial sexual encounters.

In terms of having sex for the first time maybe a little bit more about how to make it feel less highly uncomfortable at first and slightly painful, also why some women bleed and don’t bleed and what to do about that.

Some also said they were unaware of the diversity of genitalia.
Another theme that emerged was that participants felt navigating sexual encounters was awkward. Many participants wished they had been more prepared for the awkwardness and discomfort that can come with initial sexual encounters.

There are lots of logistical things to figure out your first time, and it doesn't happen too smoothly!

They frequently described it as "messy" and made comments about navigating logistical challenges.

Participants also described having unrealistic expectations which bred disappointment in these encounters. Many participants described feeling as though their initial sexual encounters did not live up to unrealistic expectations about sex being special, important, or a big deal.

I honestly wish I had known that it wasn't as special or important as all of my peers made it seem.

Some spoke specifically about shame, regret, or other negative feelings produced by these unfulfilled expectations.

Your first time having sex is absolutely not going to be even close to the way it's depicted in the movies, and you're not going to feel any different afterwards. You're going to feel exactly the same, and that's going to make you feel a little empty, mainly because you expected it to be life-changing.

Closely tied to the theme of unrealistic expectations was the theme of intrinsic motivations for sex. Participants wished they had known that sex decisions around sex should be made
based on one's own desires and comfort, and not motivated by what other people think. Sex should not be a commentary on one's value or self-worth.

_I wish that I had known that I don’t have to engage in sexual activity to make somebody like me more, or that I should be able to voice my discomfort with some of the things we were engaging in._

Others emphasized the importance of having sex in ways that promoted their own comfort.

_I wish I knew that I didn’t owe anyone anything and that my comfort and theirs goes beyond everything._

Lastly, a theme emerged around boundary setting. Responses suggested that people engaging in sexual activity should be able to be honest about whether they are experiencing pain or pleasure. They should feel comfortable communicating about their desires, boundaries, and level of comfort.

_I wish I had known that it is okay to ask for what you want. It is necessary to explore and focus on what feels right, because too often sex is about making the guy finish. Not about how it can be pleasurable for all parties involved._

The responses indicated that many participants did not feel comfortable with this type of communication. Some even mentioned knowing that there should be consent in sexual encounters, but not feeling empowered to navigate those conversations.

_That I can speak up if I feel like I am in pain, not enjoying it, or feel there was a lack of consent._
4. Discussion

The results of the current study highlight the complicated nature of sexual consent and how college students are navigating it in the context of their relationships. The study had three major findings. First, sexual self-stigma was associated with risk-taking behaviors, including alcohol use and risky sexual behavior in this college sample. Second, sexual self-stigma was associated with perceived behavioral control regarding sexual consent. Finally, sexual self-stigma was associated with decreased perceived behavioral control regarding consent among those with both positive and negative attitudes toward establishing consent.

Taken together, these results indicate that sexual self-stigma may play a role in an individual’s likelihood to assert behavioral control when setting boundaries and assessing risk, impacting various forms of health behavior. Traditional sexual assault prevention and education around consent and healthy relationships often relies upon the assumption that these health behaviors come from a lack of understanding: of sexual health risks, the importance of consent, and what consent is. The findings in this mixed methods study illustrate that these assumptions may be flawed, and that self-stigma is a contributor to sexual health behavior that must be considered and addressed.

Similar to other studies that have found sexual self-concept to be linked to both sexual risk-taking as well as sexual health information-seeking behavior (Breakwell & Millward, 1997; McKellar et al., 2017; Rudolph et al., 2020), the results of this study show a significant relationship between sexual self-stigma and risk-taking behavior. Increased internalized stigma around sexuality was associated with increased alcohol use as well as
risky sexual behavior in this sample. The qualitative data shed further light on the nature of this relationship. When asked about perceived gaps in knowledge or understanding at the time of first sexual encounter, some respondents did cite a lack of physical health knowledge which could lead to things like overuse of alcohol or taking excessive sexual risks. However, the majority of responses focused on more abstract conceptual understandings of sex and sexuality, focusing on poor communication, extrinsic motivations, and unrealistic expectations derived from peers and media. This points to extrinsically motivated decision-making as a driving force in unhealthy behavior relating to alcohol use and sex, perhaps because high levels of self-stigma reflect an anticipation of shame or judgement from others relating to one’s sexual choices and feelings. This is consistent with research around peer pressure relating to substance use, which has shown that both positive and negative peer pressure are strong influences on substance use (Keyzers et al., 2020). Similarly, engagement in perpetration or victimization of bullying, a common form peer pressure among adolescents, has been shown to be linked to sexual risk-taking (Espelage et al., 2018).

These findings have implications for prevention efforts. Having identified sexual self-stigma as a contributor to this type of risk behavior highlights a potentially important upstream risk factor for sexual violence. Previous research among university students has found a significant relationship between alcohol use and assault victimization, and a 2017 study at Columbia University and Barnard College found that the most common method of perpetration across both gender and type of assault was incapacitation due to drug and alcohol use (Caamano-Isorna et al., 2021; Mellins et al., 2017). The fact that self-stigma is a predictor of this behavior is of critical importance when tackling sexual assault prevention.
In fact, the findings in this study also suggest a more proximal connection to sexual violence in the form of a relationship with behavior around sexual consent. Results showed that although stigma did not predict attitudes toward establishing consent or overall consent scores, it did have a significant relationship with perceived behavioral control during sexual encounters. This was consistent with the qualitative findings, which indicated a high degree of similarity in definitions considering the open-ended nature of the question. The vast majority of participants suggested that consent should be a verbal agreement between parties, and other common codes included that consent should be affirmative, mutual, enthusiastic, and clear. There was some disagreement between definitions promoting active, enthusiastic consent compared to those with definitions simply focusing on consent as permission, which could certainly indicate genuine confusion about what consent is. However, in the broader context of the responses it appears that respondents generally agreed upon what consent is.

However, despite this fairly widespread agreement in the sample, the broader trend in the Yale community as well as college and universities in general, is that incidents of sexual assault and harassment continue to rise. Through the lens of the Theory of Planned Behavior (TPB), the results of this study may begin to illustrate why this is. According to the results of the multinomial logistic regression, levels of sexual self-stigma predicted low perceived behavioral control for both those with less positive attitudes toward establishing consent and those with more positive attitudes. In other words, regardless of what people’s attitudes were, stigma was influencing their perceived behavioral control. A central tenet of the TPB is that attitudes alone do not connote changed behavior. They must instead be considered alongside
subjective norms and perceived control over the behavior in question. A 2019 study by Ortiz suggests that one explanation is a lack of situational awareness. In a study examining the extent to which knowledge and understanding of consent explained intent to engage in consent communication among college students, she found that the ability to apply understandings of consent in sexual situations was the strongest predictor of behavioral intent, more so than simply having knowledge of the definition of consent (Ortiz, 2019). In other words, familiarity with the definition of consent by itself does not connote changed actions.

It is important to consider how the phenomenon of sexual self-stigma, in particular, might be contributing to this disconnect. Self-stigma is negative sexual self-concept in which people experience feelings of shame, anxiety, or stigma in relation to various aspects of sexuality. Self-stigma may be influenced by negative cultural perspectives on sex and sexuality, and other external societal pressures. In the context of TPB, it seems likely that self-stigma would be related to subjective norms, which in turn influence attitudes and behavioral control. This is consistent with the results of this study, in which we observed a marked disconnect between what people think and say and what they do.

In this study, we observed that many participants were able to define consent and endorse a positive attitude toward establishing it. However, both the quantitative and qualitative results indicated far more discomfort when it came to discussing it openly or acting upon it. Self-stigma appears to impact how people perceive the environments in which they have these conversations. For example, when participants were asked to think about environments that make them feel comfortable talking about sex and relationships, they
emphasized they did not want to feel judged. Their comments suggested that there may have been shame or judgment attached to asking questions or enforcing boundaries. For example, one participant said “[I] need to be comfortable with the people I’m with and primarily need to trust that they wouldn’t judge me for having questions/conversations.” This seems to connote internalized sexual self-stigma, in which a person’s expression of sexuality is imbued with shame or worry. This was also mirrored in the results of the linear regression model indicating that sexual self-stigma was associated with decreased perceived behavioral control around establishing consent.

Additionally, self-stigma appeared to impact comfort with communication. Qualitative results in this study showed that many participants wanted distance from the subject of sex and relationships. For some, anonymous environments in which subjects of sex and relationships are being approached as a more academic or clinical concept felt most comfortable. This general discomfort with topics of sex and relationships caused some respondents to express difficulty with communicating boundaries, despite knowing that they should. For example, one person wrote, “I wish I had known how to best communicate during sex--i wasn't really sure how direct to be without ruining the mood...” This trend was particularly clear when discussing pleasure. Many respondents expressed a lack of knowledge around how to communicate about pleasure, which could stem from internalized shame around sexual desire and pleasure, a central part of sexual self-stigma.

Given these findings, it seems that self-stigma must be taken seriously in the prevention of sexual assault. It is associated with risky behaviors that have, in turn, been linked to assault victimization. It is predictive of behavioral control around establishing consent.
consent, regardless of how positive peoples’ attitudes toward consent are. Qualitative data reveals concepts that likely stem from self-stigma to be at the route of gaps in knowledge and situational awareness. While sexual assault prevention continues to focus on defining consent and highlighting its importance, in the following section we will take a closer look at what it would mean to shift away from an emphasis on definitions and attitudes and toward an emphasis on decreased stigma and increased behavioral control.

5. Limitations

This study was subject to various limitations and future research should seek to reproduce these results in larger, more diverse populations. These results are limited in their generalizability. The Yale University undergraduate population is comprised of high-achieving, well-educated students that may differ in other significant ways from other university students. Although possibly representative of the Yale College community, similar work should be undertaken in communities more representative of the demographic makeup of the national university study body population. This study was majority female, white, and higher income than the national average. The majority of students in the sample were heterosexual and cis-gender, so future research should examine the potential influence of sexual orientation and gender identity on the topics explored here. The sample size was also small, and undertaking a similar study in a larger population would allow for considerably more power to conduct more nuanced analyses. Finally, study results may have been affected by non-response bias or sampling bias. Those enrolled in the Psychology 101 class or seeking
to be entered into the gift card lottery may have differed in particular ways from those not entered in the study, so random sampling in future studies will be important.

6. Implications

6.1 Policy

The results of the current study suggest a need for institutional policies that acknowledge the underlying causes of sexual assault perpetration. Despite the growing body of research highlighting the potential importance of underlying phenomena, such as sexual self-concept, the majority of sexual assault prevention policies, particularly on college campuses, focus almost exclusively on emphasizing the importance of consent and punishing perpetrators of sexual misconduct. Institutional policies such as affirmative consent standards and Title IX are important for establishing standards of conduct and enforcing consequences for those who do not uphold them, but they do little to prevent misconduct in the first place because they do not address the root causes. These policies are often used in place of policies and programs seeking to make meaningful culture shifts to promote safe and healthy campus sexual culture, and as such they are unlikely to succeed in preventing sexual assault and misconduct.

One clear example of this is the way in which affirmative consent standards have been mobilized on college and university campuses. Although there is significant variation in the exact language used in these policies, affirmative consent generally refers to a standard of consent that includes clear verbal or nonverbal communication of agreement to engage in
sexual activity (Dougherty, 2018; Hardesty et al., 2021). Affirmative consent standards reflect a shift away from defining that which is prohibited (rape, attempted rape, sexual assault) to defining the opposite (consensual sex). Although Antioch College was the first institution to implement such a policy back in 1990, the early 2010s brought with it a wave of colleges and universities around the country adopting affirmative consent standards into their codes of conduct and sexual assault adjudication procedures in response to increasing attention to the problem of campus sexual assault. In 2014, California became the first state to adopt “Yes Means Yes” affirmative consent legislature which also mandates all academic institutions receiving state funding to adopt similar policies on their campuses. New York has since adopted a similar policy, and affirmative consent legislature of this kind is being considered by numerous other states (Emba, 2015).

Although it has some notable critics, affirmative consent, in and of itself, has been widely embraced as a more empowering way of defining sexual consent. This was quite apparent in the qualitative responses from the current study, in which many respondents used specific language that described consent as affirmative or otherwise indicated that consent should include more communication than just a negative response to sexual advances. The problem with affirmative consent, therefore, lies not in the actual definition, but rather how it has been put to use. For many institutions of higher education, affirmative consent is not just a policy for adjudicating sexual assault cases, but has also come to act as the foundation of most campus sexual assault programs. Posters emblazoned with “consent is sexy” and lessons, precisely like the one I taught to my ninth-grade health class, have become ubiquitous. Consent’s centrality to sexual assault prevention efforts can likely be attributed
to its simplicity. It draws clear, unambiguous lines between appropriate, acceptable sexual behavior and assault. Furthermore, several experts have also argued that it is attractive because it is a far easier, more visible action than actually transforming campus sexual culture (Kulbaga & Spencer, 2019).

In contrast, however, consent as a preventive measure has been critiqued on many of the same grounds. Though it may provide clarity in the definition of consent, some studies have shown that college relationships are often characterized by ambiguity. Hardesty et al (2021) found that in many cases, students found this ambiguity useful in that it allowed them to shape and reshape their interpretations of events and relationships to meet different needs. Affirmative consent’s demand for clarity reduced students’ ability to have this desired ambiguity and left students questioning what consent would even look like in the usually ambiguous sexual culture in which they found themselves (Hardesty et al., 2021). Others have also critiqued consent on the grounds that as a concept, it does not provide the situational awareness necessary to act upon it (Fischel, 2019; Ortiz, 2019). This is consistent with the findings of this study, in which positive attitudes toward consent and perceived behavioral control around consent followed disparate trends among participants.

While a thorough review of the critiques of affirmative consent is beyond the scope of this thesis, one thing has become clear: whatever the strategies being used by colleges and universities, they have not “solved” the problem of sexual assault. The numbers of reported sexual assaults continue to rise, and while some of this trend may be attributed to increased reporting, the fact remains that sexual assault remains prevalent and warrants more thoughtful attention. Policy that acknowledges these realities is a good place to start.
Institutional

One gap in institutional policy to prevent sexual misconduct highlighted by the findings of this study is evaluation. Though the Clery Act mandates the collection of data around campus sexual misconduct, it does not mandate any action taken as a result of trends observed in that data. It would behoove colleges and universities to go beyond the demands of that legislation and intentionally evaluate existing sexual assault prevention policies and associated programs against their stated objectives. Implementing surveys, such as the one utilized in the current study, will help administrators to better identify predictors of the behavior they hope to prevent and identify potential interventions.

Perhaps as a component of this formal evaluation process, institutions should also pay attention to policies such as mandatory reporting. Some universities have begun to expand policy to compel more employees to report disclosures of sexual assault, but this change has been heavily critiqued by some who say that this can be harmful to survivors by forcing them to unwillingly engage with systems they hope to avoid (Holland et al., 2018; Kulbaga & Spencer, 2019). Beyond just the impact this may have on survivors, it may also discourage conversation around sex and sexual misconduct on a broader level, which could exacerbate sexual self-stigma and stand at odds with the goal of assault prevention.

These evaluative processes should also interrogate the extent to which current systems for preventing and handling sexual misconduct may be imbued with various biases. Kulbaga and Spencer (2019) make a compelling argument that consent and sexual assault prevention must be understood alongside power and oppression. They argue that we must first ask: “who has the power to be protected from violation?” Ensuring that all systems are
accessible and inclusive to all students will be integral to any meaningful culture shift to promote safe sexual environments on college and university campuses.

In general, given the continuing increases in incidents of campus sexual misconduct, colleges and universities should view state and federal policies regarding misconduct as the bare minimum and strive to do better for their students.

State

The results of this study highlighted a potential gap between attitudes toward consent and behavior. If these results are supported by future research, state policy-makers should strongly consider expanding affirmative consent policies to include preventative components that center on behavioral control and situational awareness. Suggested details can be found in the following section.

Looking even more distally from incidents of sexual assault, it may also be prudent to reassess legislature on sex education. In particular, the results of this study showed a difference between representations of consent and healthy relationships in sex education classes. Significantly more students reported having received a lot of information about consent in their sex education than reported having received information about healthy relationships. Given the concerns raised by the rest of the findings, it seems as though healthy relationships and situational awareness warrant further attention. In fact, according to the Guttmacher Institute, as of April 1, 2021, only 30 states have requirements for sex education taught in schools. 31 states require the provision of information on healthy relationships, but only 10 states require the information that is provided be inclusive with
regard to sexual orientation and only 9 require that it be culturally appropriate and unbiased with regard to race, sex, or ethnicity (Sex and HIV Education, 2016). Future policy should attempt to address this gap and provide culturally appropriate and inclusive education to prepare students to engage in healthy relationships as they approach adulthood.

**Federal**

At the federal level, consideration should be given to expanding Title IX to include preventative measures on college and university campuses. While it affords critical protections for victims of sexual assault, further thought should be given to what it might look like to prevent discrimination on the basis of sex before such a traumatic incident has occurred.

Additionally, consideration should be given to ending federal funding for abstinence-only sex education and educational programs which promote homophobia and transphobia. If policy-makers want to make a meaningful difference in ending sexual assault and promoting the health and well-being of adolescents and young adults, they must go beyond symbolic legislature that provides consequences for harm already done and get serious about prevention. Helping students to develop healthy sexual self-concept and minimize internalized stigma is essential to this preventative effort.

**6.2 Practice**

Policies that foster healthy sexual climates on college campuses are critically important, but they should also be complemented by sexual assault prevention programming
that pays attention to reducing sexual self-stigma and fostering sex positivity and behavioral control, rather than just communicating the definition of consent. This study highlights one facet of a continuing discrepancy between sexual assault prevention research and where the majority of sexual assault prevention programs focus. Prior research has pointed to social-emotional skills and family-level factors as important predictors of sexual violence. The current study highlights another related factor - sexual self-concept - as similarly important in understanding behavior around sexual activity and consent.

In a practical sense, this requires reevaluating the focus and scope of sexual assault prevention programming. Given the results of the current study as well as the growing body of research on social and emotional skills as protective factors for assault perpetration, those designing and implementing future campus prevention programs - as well as prevention programming in other settings - should consider shifting away from curriculum where consent and bystander intervention are centered and toward a model that considers sexual self-concept.

Understanding what consent is and how to intervene when a situation seems like it may lead to nonconsensual sex is critically important, but given the findings in this study, it appears the impact of that type of knowledge may be diminished in the absence of healthy sexual self-concept. Promoting healthy understandings of sexuality on an individual level may be an important step toward creating campus sexual environments conducive to healthy conversations about consent and boundary-setting.

Additionally, programming that focuses on healthy relationships and promotes situational awareness may be useful in bridging the apparent gap between positive attitudes
toward establishing consent and the actual behaviors associated with obtaining consent. Relying once again upon the Theory of Planned Behavior framework, it may be important to lay the groundwork for the behavior we hope to encourage, such as self-efficacy, assertive communication, and positive self-expression, rather than providing definitions and scripted scenarios that do not translate to real-world behavior.

6.3 Research

This research has suggested that self-stigma may be playing a role in the disconnect between positive attitudes toward consent and actual consent behavior. If this is indeed the case, significant further research is needed to elucidate the nature of this relationship, as well as those factors which contribute to the development of self-stigma. Despite having been hypothesized to be predictors of self-stigma in this study, neither family cohesion nor sexual and reproductive health knowledge were found to have significant associations with this construct. Future research should seek to identify predictors of self-stigma, particularly those factors which may be protective.

Due to the nature and timing of this study, it was not possible to link the variables studied here with actual experiences of assault and harassment victimization and perpetration. Future research should attempt to do so in an effort to further examine the relationship between attitudes and behavior.

If true change is to be made in preventing sexual assault and improving the health and well-being of college students (and others), we must acknowledge that consent is
complicated and our notions of it are colored by our internalized concepts of sexuality, shame, and self-worth. As one participant put it, “sexual activity is messy” - rather than trying to tidy it up, it is imperative that we learn more about the nature of that mess.
## Appendix A

### Table 1. Demographic characteristics of the sample (N=160)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>M (SD)</th>
<th>n(%)</th>
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<tbody>
<tr>
<td>Age</td>
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<td>non-Hispanic Black</td>
<td>23 (14.4)</td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>21 (13.1)</td>
<td></td>
</tr>
<tr>
<td>Multiracial</td>
<td>14 (8.8)</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>106 (66.3)</td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>9 (5.6)</td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>7 (4.4)</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>31 (19.4)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7 (4.4)</td>
<td></td>
</tr>
<tr>
<td>Financial Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>57 (35.6)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>100 (62.5)</td>
<td></td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$50,000</td>
<td>33 (20.6)</td>
<td></td>
</tr>
<tr>
<td>$50,000-$100,000</td>
<td>37 (23.1)</td>
<td></td>
</tr>
<tr>
<td>$100,000+</td>
<td>85 (53.1)</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2. Means and standard deviations of Sexual Consent Scale and subscales

<table>
<thead>
<tr>
<th>Sexual Consent Scale</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Scale</td>
<td>3.09 (.31)</td>
</tr>
<tr>
<td>(Lack of) perceived behavioral control subscale</td>
<td>1.67 (.69)</td>
</tr>
<tr>
<td>Positive attitude toward establishing consent subscale</td>
<td>4.32 (.71)</td>
</tr>
<tr>
<td>Indirect behavioral approach to consent subscale</td>
<td>3.07 (.83)</td>
</tr>
<tr>
<td>Sexual consent norms subscale</td>
<td>2.85 (.87)</td>
</tr>
<tr>
<td>Awareness and discussion subscale</td>
<td>4.10 (.85)</td>
</tr>
</tbody>
</table>
**Table 3.** Bivariate relationships between analytic study variables using Pearson’s correlation (N=160)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>-0.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Gay/Lesbian/Bisexual</td>
<td>-0.09</td>
<td>0.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>On financial aid</td>
<td>0.02</td>
<td>0.05</td>
<td>0.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Asian</td>
<td>-0.14</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.07</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Black</td>
<td>0.07</td>
<td>0.02</td>
<td>-0.03</td>
<td>0.15</td>
<td>-0.22**</td>
</tr>
<tr>
<td>7</td>
<td>Hispanic</td>
<td>-0.12</td>
<td>0.15</td>
<td>0.08</td>
<td>0.06</td>
<td>-0.21**</td>
</tr>
<tr>
<td>8</td>
<td>Multiracial</td>
<td>-0.11</td>
<td>0.05</td>
<td>0.16*</td>
<td>-0.09</td>
<td>-0.17*</td>
</tr>
<tr>
<td>9</td>
<td>Income $50-100k</td>
<td>-0.09</td>
<td>0.18*</td>
<td>0.09</td>
<td>0.24**</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>10</td>
<td>Income less than $50k</td>
<td>0.15</td>
<td>0.02</td>
<td>-0.10</td>
<td>0.37**</td>
<td>0.11</td>
</tr>
<tr>
<td>11</td>
<td>Family Cohesion Score</td>
<td>0.03</td>
<td>-0.09</td>
<td>-0.07</td>
<td>-0.11</td>
<td>-0.06</td>
</tr>
<tr>
<td>12</td>
<td>Sexual Consent Survey (SCS) Score</td>
<td>0.07</td>
<td>0.04</td>
<td>0.06</td>
<td>-0.05</td>
<td>-0.08</td>
</tr>
<tr>
<td>13</td>
<td>SCS: (Lack of) perceived behavioral control subscale</td>
<td>-0.01</td>
<td>0.03</td>
<td>0.02</td>
<td>-0.05</td>
<td>-0.01</td>
</tr>
<tr>
<td>14</td>
<td>SCS: Positive attitude toward establishing consent subscale</td>
<td>0.01</td>
<td>0.05</td>
<td>0.08</td>
<td>0.06</td>
<td>-0.06</td>
</tr>
<tr>
<td>15</td>
<td>SCS: Indirect behavioral approach to consent subscale</td>
<td>0.08</td>
<td>-0.04</td>
<td>-0.04</td>
<td>-0.08</td>
<td>-0.03</td>
</tr>
<tr>
<td>16</td>
<td>SCS: Sexual consent norms subscale</td>
<td>0.04</td>
<td>-0.07</td>
<td>-0.06</td>
<td>-0.02</td>
<td>-0.02</td>
</tr>
<tr>
<td>17</td>
<td>SCS: Awareness and discussion subscale</td>
<td>0.07</td>
<td>0.16</td>
<td>0.19</td>
<td>-0.07</td>
<td>-0.12</td>
</tr>
<tr>
<td>18</td>
<td>Sexual Self-Stigma Score</td>
<td>0.09</td>
<td>-0.19*</td>
<td>-0.08</td>
<td>-0.02</td>
<td>0.03</td>
</tr>
</tbody>
</table>

-0.12

0.10 | 0.04 | 0.03 | -0.06 | -0.29** |

0.13 | -0.03 | <0.01 | -0.19* |

0.03 | 0.12 | 0.07 | -0.01 | 0.07 |

-0.01 | 0.11 | 0.09 | 0.03 | -0.02 | 0.55** |

0.12 | -0.04 | -0.05 | -0.04 | 0.04 | 0.08 | -0.46** |

<0.01 | 0.02 | 0.10 | -0.06 | 0.10 | 0.55** | 0.34** | -0.47** |

<0.09 | 0.05 | 0.02 | -0.02 | 0.11 | 0.60** | 0.27** | -0.40** | 0.56** |

0.03 | 0.14 | -0.05 | -0.07 | -0.06 | 0.28** | -0.18* | 0.38** | -0.16 | -0.14 |

-0.19 | -0.02 | -0.02 | -0.06 | 0.07 | 0.01 | -0.10 | -0.10 | 0.16 | 0.11 | 0.06 |

* - Correlation is significant at the .05 level

** - Correlation is significant at the .01 level
Table 4. Multinomial logistic regression predicting high-low pairings of Perceived behavioral control and Attitudes toward establishing consent

<table>
<thead>
<tr>
<th></th>
<th>Low PBC/Low Attitudes</th>
<th>High PBC/Low Attitudes</th>
<th>Low PBC/High Attitudes</th>
<th>High PBC/High Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>OR</td>
<td>95% CI</td>
<td>B (SE)</td>
</tr>
<tr>
<td>Model 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ref. low-low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self-Stigma</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Model 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ref. high-low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self-Stigma</td>
<td>2.62</td>
<td>(1.05)*</td>
<td>13.70</td>
<td>1.75-107.08</td>
</tr>
<tr>
<td>ref. low-high</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ref. low-high</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self-Stigma</td>
<td>0.75</td>
<td>(1.18)</td>
<td>2.12</td>
<td>0.21-21.22</td>
</tr>
<tr>
<td>ref. high-high</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ref. high-high</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Self-Stigma</td>
<td>2.17</td>
<td>(0.83)*</td>
<td>8.78</td>
<td>1.73-44.51</td>
</tr>
</tbody>
</table>

Note: Analyses included control for demographic variables (dummy codes for gender, sexual orientation, race/ethnicity, financial aid status, and household income; age was included as a continuous variable).

*p < .05; ** p < .001

Appendix B

Figure 2
Figure 3

How much have you learned from each of these sources about condoms?

Figure 4

How much have you learned from each of these sources about STDs?
Figure 5

Figure 6
### Appendix C

**Question:** Please describe your understanding of what sexual consent is.

<table>
<thead>
<tr>
<th>Code</th>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td>Verb</td>
<td>Any mention of verbal expressions of consent including any confirmation, agreement, or permission to engage in sexual activity that involves verbal communication.</td>
</tr>
<tr>
<td>Non-verbal</td>
<td>NonVerb</td>
<td>Any mention of non-verbal expressions of consent, including physical communication, body language, or non-verbal signals or cues communicating consent to engage in sexual activity.</td>
</tr>
<tr>
<td>Enthusiastic</td>
<td>Enth</td>
<td>Any mention of active, proactive, positive, or enthusiastic communication about consent.</td>
</tr>
<tr>
<td>Clear</td>
<td>Clear</td>
<td>Any mention of consent that is clear, unambiguous, or explicit. Any mention of communication that is specific about what someone is consenting to or wants to do. Any mention of &quot;certain behavior&quot; or &quot;specific sexual act&quot; that is being agreed to. Any mention of consent that is unquestionable.</td>
</tr>
<tr>
<td>Coherent</td>
<td>Coherent</td>
<td>Any mention of consent that is sober. Any mention of consenting people being capable of making decisions. Any mention of consenting people being fully informed or aware of what they are consenting to.</td>
</tr>
<tr>
<td>Voluntary</td>
<td>Vol</td>
<td>Any mention of consent that is voluntary, willing, non-coerced, or of one's own volition. Any responses mentioning desire or wanting.</td>
</tr>
<tr>
<td>Continuous</td>
<td>Cont</td>
<td>Any responses that mention continuously seeking consent to initiate or continue sexual activity. Mentions of consent that is ongoing, happens across multiple encounters, is not assumed, or is consistent. Any responses indicating that consent can be revoked.</td>
</tr>
<tr>
<td>Affirmative</td>
<td>Affirm</td>
<td>Any responses that distinguishes between &quot;yes&quot; and &quot;no&quot;, including those that clarify differences between &quot;yes means yes&quot; and &quot;no means no&quot;. If the response includes &quot;affirmative.&quot;</td>
</tr>
<tr>
<td>Mutual</td>
<td>Mutual</td>
<td>Any mention of consent that is mutual. Any mention of &quot;both parties&quot; or &quot;all parties&quot; consenting or agreeing to something or indicating they both want the same thing. Any mention of making decisions together.</td>
</tr>
</tbody>
</table>
**Question:** What type of environment makes you feel most comfortable having conversations about sex and relationships?

<table>
<thead>
<tr>
<th>Code</th>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>Group</td>
<td>Responses that mention small groups and/or groups of people</td>
</tr>
<tr>
<td>Private</td>
<td>Private</td>
<td>Any mention of private, one-on-one conversations or environments that are alone, anonymous, individual, or confidential. Any mention of a specific private space (e.g. &quot;my room&quot;), or other isolated or secluded spaces.</td>
</tr>
<tr>
<td>Familiarity</td>
<td>Famil</td>
<td>Any mention of situations or environments that have feelings of familiarity, trust, honesty, safety, respect, seriousness or take place among friends, family or peers.</td>
</tr>
<tr>
<td>Quiet</td>
<td>Quiet</td>
<td>Any mention of quiet or calm environments</td>
</tr>
<tr>
<td>Non-judgmental</td>
<td>NJudge</td>
<td>Any responses that mention non-judgmental or sex-positive environments or those where thoughts can be expressed freely.</td>
</tr>
<tr>
<td>Women</td>
<td>Women</td>
<td>Any responses that indicate more comfort with conversations with women or female-identifying people or being less comfortable having these conversations with men.</td>
</tr>
<tr>
<td>Connected</td>
<td>Connect</td>
<td>Any responses that indicate increased comfort with environments that involve connectedness, closeness, comfort, openness, vulnerability, kindness, intimacy, or conversations with an intimate partner. Any responses mentioning shared or relatable past experiences.</td>
</tr>
<tr>
<td>Formal</td>
<td>Formal</td>
<td>Any mentions of workshops, or educational, academic, or therapeutic and/or medical environments</td>
</tr>
<tr>
<td>Informal</td>
<td>Informal</td>
<td>Any mentions of informal, relaxed, or casual environments</td>
</tr>
</tbody>
</table>
**Question:** What do you wish you had known before engaging in sexual activity for the first time?

<table>
<thead>
<tr>
<th>Code</th>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfort</td>
<td>Comfort</td>
<td>Any responses indicating that sex should feel comfortable or safe. Mentions of sex not involving pressure or not feeling rushed.</td>
</tr>
<tr>
<td>Genitalia</td>
<td>Genitalia</td>
<td>Any mention of genitalia diversity in appearance or physical nature.</td>
</tr>
<tr>
<td>Physical</td>
<td>Physical</td>
<td>Any responses referencing condoms, contraceptives, STDs, or physical anatomy.</td>
</tr>
<tr>
<td>Realistic</td>
<td>Realistic</td>
<td>Any responses referencing that sex is different or less &quot;life altering&quot; than someone expected. Any responses indicating feeling that sex is more awkward, messy, or shorter/longer than expected. Any responses that reference expectations that the person had around sex that were not met in reality.</td>
</tr>
<tr>
<td>Painful</td>
<td>Pain</td>
<td>Any mention of pain or lack of pleasure involved in sex the first time.</td>
</tr>
<tr>
<td>Pleasure</td>
<td>Pleasure</td>
<td>Any responses indicating that sex should be pleasurable or that masturbation is okay or good.</td>
</tr>
<tr>
<td>Extrinsic</td>
<td>Extrinsic</td>
<td>Any responses indicating that it is okay to have discussions about sex beforehand or to speak up about needs or wants during sexual activity. Any responses commenting on the authority to communicate needs and wants.</td>
</tr>
<tr>
<td>Communication</td>
<td>Comm</td>
<td>Any responses referencing clarity around what consent is or what it looks or sounds like. Any references to lack of consent.</td>
</tr>
<tr>
<td>Consent</td>
<td>Consent</td>
<td>Any responses referencing feelings of regret or shame.</td>
</tr>
<tr>
<td>Regret</td>
<td>Regret</td>
<td>Any responses referencing awkwardness or logistical challenges involved in first sexual encounters.</td>
</tr>
<tr>
<td>Awkward</td>
<td>Awkward</td>
<td>Any responses indicating that sex should feel comfortable or safe. Mentions of sex not involving pressure or not feeling rushed.</td>
</tr>
</tbody>
</table>
References


