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School Counselor Strategies for Preventing Sexual Risk Taking Behaviors in Adolescents

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School Counselor Strategies for Preventing Sexual Risk Taking Behaviors in Adolescents

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School Counselor Strategies for Preventing Sexual Risk Taking Behaviors in Adolescents

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Sexual development and interest in sex is a normal part of adolescent development, but the negative outcomes of unprotected intercourse can result in life changing consequences such as an unplanned pregnancy or a sexually transmitted infection. Although the prevalence of these consequences have improvement over the past decade, the United States still has one of the highest teen pregnancy rates and highest prevalence of youth sexually transmitted infection among developed countries. In this report, the determinants that lead adolescents to engage in sex and fail to use contraceptives are reviewed. With knowledge on what factors contribute to adolescent sexual risk taking behaviors, counseling strategies can be implemented to prevent and intervene, and the school counselor is in a prime setting for delivery. The prevention strategies that are covered in this review are grouped into five categories. They are education, skill building, enhancing student development, involving parents and families, and implementing programs.

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Introduction

In a national survey in 2007, the number of students in grades 9-12 who had ever engaged in sexual intercourse was 47.8%. Among these sexually active students, 61.5% had used a condom during their last sexual intercourse (Trends in the Prevalence, n.d.). Although these statistics show improvement over the past decade, correct condom use must occur every time to effectively control the spreading of STIs and prevent pregnancy, and only 28% of females and 47% of males report using a condom for every instance of vaginal sex (Franzetta, Terry-Humen, Manlove & Ikramullah, 2006). The negative outcomes of unprotected sexual intercourse are widely known and include the transmission of sexually transmitted infections (STIs) including HIV/AIDS as well as risk of pregnancy. The United States has one of the highest teen pregnancy rates as well as the highest prevalence of youth STI infection among developed countries (Milhausen et al., 2008). This teen pregnancy rate is 1/3 times higher than England and Wales, 2 times higher than Canada, and 5 to 10 times higher than Denmark, Korea, and Japan. Likewise, adolescents account for one fourth of all STI cases, and the number of HIV cases increased among 15-19 year olds from 2001 to 2004 (Campos, 2002; Walcott, Meyers & Landau, 2008). These findings show the need for further prevention and intervention in adolescent sexual risk taking behavior and a better understanding of the factors contributing to this.

First, an overview of the function of adolescent development provides a point of reference for insight into these desires to engage in sex. It is imperative to remember that sexual development is a natural and normal occurrence in the human lifespan (Powell, 2007). However, the risks of engaging in sexual risk taking behaviors as a result of that behavior can result in life changing consequences. There is even debate that sexual intercourse, conducted safely or not, can be harmful to psychological wellbeing. The development of adolescent sexuality includes

aspects of physical changes in the body like hormones creating new feelings of desire and arousal and reproductive systems maturing (Diamond, 2006). Concurrent to the sexual development of adolescents is their cognitive development including the maturation of their frontal lobes, the decision making part of the brain. The cognitive and sexual development of adolescents work together to create a unique time period where adolescents are physically ready to have sex but do not yet have the complete cognitive abilities to appropriately respond to risk (Sylwester, 2007). It is important for counselors to understand adolescent development as it provides a context for the decisions adolescents and helps to explain why, despite the obvious risks involved and society's disapproval, adolescents decide to engage in sexual behaviors.

To further understand the sexual risk taking decisions that adolescents make that can lead them to teen parenthood or STI transmission, a conceptual framework, collaborated on by well-known psychologists Bandura, Becker, Fisbein, Knafer, and Triandis, was created to identify the important variables of behavioral intentions and enactment of sexual behavior. These psychologists were chosen because their major theories on human behavior were being used commonly to understand health risk behaviors. This collaboration identified five immediate determinants of behavior, or proximal determinants, as well as five factors that influence behavioral intention (Guilamo-Ramos, Vincent, Jaccard, Dittus, Gonzalez, & Bouris, 2008). Aside from these determinants organized in the conceptual framework, it is important to remember that nonsexual factors like biological traits and the environment, including that of the school, can influence the choices of adolescents (Kirby, 2002). Parents, the community, peers, society, and socioeconomic status also play important roles and thus we cannot leave all responsibility with the schools (Powell, 2007; Vincent, 2007). With knowledge on what factors

contribute to adolescents engaging in sex and failing to use contraceptives, counseling strategies can be implemented to prevent and intervene.

Being in the schools, the counselor is in a prime setting to reduce the prevalence of sexual risk taking behaviors. Challenges that might be met in the community do not occur in the organized ongoing structure of the school. There is also easy access to one's population as adolescents are required to attend school, spending as much as 5400 hours there (Conyne, 2004). The school counselor can initiate a variety of counseling strategies. A selection of strategies that are both practical and easy for the school counselor to initiate and empirically validated are covered in this review. A consideration for ethical guidelines is also covered, as when discussing sexual risk taking with students it can be unclear when confidentiality should be broken (Moyer & Sullivan, 2008). The strategies for interventions utilizing preventative counseling covered in this review are grouped into five categories. They are education, skill building, enhancing student development, involving parents and families, and implementing programs.

Education is the most frequently used strategy, however researchers have shown that addressing knowledge alone without including other strategies like skill building is not an effective means of prevention (Ryan, Franzetta & Manlove, 2007). Education provides the knowledge base necessary to help adolescents make informed decisions about sexual risk taking and skill building on decision making and the communication skills necessary to convey that decision to partners are important for helping adolescents follow through. Research has also shown that one can decrease an adolescent's risk for sexual risk taking behaviors and their consequences by enhancing positive student development (Conyne, 2004). The research on improving self-concept, pro-social connectedness, and emotional well being as preventative factors are detailed.

Another strategy for preventing sexual risk taking behaviors that is involving parents and family members. Parents are a powerful influence on adolescent's sexual behaviors as shown in a survey where 87% said that if parents were more communicative with them about sex, contraception, and pregnancy, it would be easier to postpone sex and avoid pregnancy (Lederman, Chan, & Roberts-Gray, 2008). Programs involving parents have been shown to be effective interventions (Lederman et al., 2008). It has also been found that the content of the messages parents give may be more important than the quantity. Specific messages from parents can decrease, but also increase sexual activity (Aspy, et al., 2007). The last strategy for preventing sexual risk taking behaviors is implementing an established effective program within the school. Presently, our country is in debate about what kind of education our adolescents should receive (Kirby, 2002b). The differing goals are represented in programs called "comprehensive" or "abstinence-only" sex education programs (Campos, 2002). In the discussion of this strategy, evidence for what programs are best suited to increasing contraceptive use and preventing sexual behaviors is given.

In this literature review, ways in which the school counselor can benefit their students is divided into several sections. First, the importance of understanding the function of sex in adolescent development will first be considered. Second, an overview of a conceptual framework representing a combination of many popular health risk theories is considered to better understand the determinants of sexual risk taking behavior. Next, an introduction to the counseling strategies is given with consideration to the ethical dilemmas faced. This is followed by research and evidence for each of the strategies. The strategies recommended are education, skill building, enhancing student development, involving parents and families, and implementing programs. The paper concludes with an overview of the major findings covered in the review.

Chapter 1: Adolescent Development

Sexuality in adolescence is commonly portrayed as a source of problems and risks (Diamond, 2006). However, it is also important to understand that this is a normative and integral part of development for all humans. Developing a healthy and positive sexual identity should be happening at this time (Powell, 2007). Of course, even if interest in sexuality and sex itself is a healthy aspect of life, the possible consequences of unsafely participating in the activity are problematic.

Some biological aspects of sexual development can facilitate adolescents engaging in sex. An adolescent's reproductive system becomes capable of creating children long before and adolescent may be psychologically or financially ready. As teens age, they are more likely to have sex because of physical maturity and hormone levels. The sexual drive also emerges during this time causing adolescents to feel sexually aroused unintentionally (Sylwester, 2007; Bradley et. al., 1999). Sex is a part of our natural development and is not a health related or psychosocial risk unless done at an early age of 10-14 years (Walcott, Meyers & Landau, 2008; Brendgen, Wanner & Vitaro, 2007). Early pubertal development relative to peers has been a significant predictor for early involvement in intimate relationships, ideation of sex, the onset of intercourse, an increase in sexual partners and level of sexual involvement two years later (Gullotta & Adams, 2005).

Although adolescent sexual development is normal, the possibility of sexual intercourse having a negative impact on the adolescent's psychological wellbeing has been debated. Particularly, it has been debated that depressive symptoms result from early onset. However, Sabia (2006) has not found empirical support for this idea. Instead, early sexual debut is another observable indicator of depression but not a causal factor. Early onset of teen sex is found to

have other negative outcomes, and adolescents are having sex at increasingly younger ages (Bekaert, 2005). Girls whose onset of sexual intercourse is between the ages of 10 and 14 are more likely to have sex with high risk partners (Brendgen, Wanner & Vutaro, 2007). Adolescents who engage in sexual activity early have an increased number of partners and an increased risk of pregnancy and STIs (Guilamo-Ramos, Jaccard, Dittus, Gonzalez & Bouris, 2008). Early onset is also linked to having a negative effect on educational progress (Sabia, 2006).

A second important component of adolescent development is cognitive development. The brain is very active in its changes during adolescence as evidenced in changes in the frontal lobes of the brain. This area of the brain helps with reflective problem solving, the process of determining the appropriate responses for how to solve problems, and is still developing until late adolescence. The sensory lobes, developed during childhood, allow for the ability to recognize and analyze challenges. However, adolescents have immature frontal lobes. Therefore, they may have the ability to carry out a complex action but they lack the ability to determine if it's a good idea. They cannot realize their decisions may be inappropriate or even dangerous (Sylwester, 2007).

The quickly paced sexual development paired with a still changing cognitive development can leave adolescents ill prepared to deal with risky situations such as sexual behaviors. When adolescents face an experience involving risk, an arousing stimulus causes adolescents to analyze the current state of their bodies and brains, estimate the amount of support they will receive, and calculate whether the outcomes will be positive or negative. From this assessment, their emotions respond optimistically, with joy, anticipation, or trust, or pessimistically, with fear, anger, or grief. However, many things can impair the accuracy of such

an assessment. Drugs, illness, belief systems, and immature judgment are factors that work in favor of or against an adolescent making an accurate prediction of whether they can handle a risky situation (Sylwester, 2007). For most of their lives, adolescents have had parents or other adults assume responsibility for confronting risks on their behalf. As individuals reach adolescence, the need for autonomy leads adolescents to begin to make their own decisions in risky situations. However, the negative results of the risky situations handled in adolescence are more severe than those from childhood decisions (Sylwester, 2007). A bruised leg from a poor outcome assessment of the risk involved with monkey bars is far less impactful than becoming pregnant or the lifelong maintenance of managing a viral STI resulting from poor judgment about engaging in unprotected sex.

Chapter 2: Theoretical Framework

There are many decisions made along the path to teen parenthood. Miller, Sage, and Winward detail this decision making process. According to their model, there are four decisions: (1) the sexual question of whether to have intercourse, (2) the contraceptive question of whether to use contraception, (3) the pregnancy question of whether to have the baby, (4) and the parenting question of whether to keep the baby (Miller et al., 2005). With the goal of determining methods of preventing adolescent risk taking behaviors, prevention and intervention are focused on the sexual question and the contraceptive question.

There are literally hundreds of factors that can affect both the decision to engage in sex and to use contraception (Gullotta & Adams, 2005). Also, it has been shown that causes for problem behaviors are often unique for each individual and are not common or predictable. Several theoretical frameworks for organizing and conceptualizing the many individual factors is available, though a particular conceptual framework developed by The National Institute of Mental Health is especially useful as it draws on five major theories of human behavior (Guilamo-Ramos et al., 2008).

To create this framework, the National Institute of Mental Health gathered the leading theorists of five major theories that were commonly being used to examine health related behaviors. These theories were (1) social learning theory represented by Bandura, (2) the theory of reasoned action represented by Fishbein, (3) self-regulation theories represented by Kanfer, (4) the theory of subjective culture represented by Triandis, (5) and the health belief model represented by Becker. After some debate, the five theorists developed the following framework to describe the variables related to engaging in sex. Although the model was created with the sexual question of Miller's model in mind, I argue that as a behavioral model related to sex, it

could also be used to organize and categorize the variables related to the contraceptive question as well. The framework organizes the categories of proximal determinants and immediate determinants of both engaging in sex and contraceptive use.

The proximal determinants are the factors that influence behavioral intention. An individual must first intend to enact the behavior before it is performed. The proximal determinants are (a) expectancies, or the perceived consequences of behavior, (b) social norms, which include both perceptions of approval and disapproval as well as the perceived prevalence of the behavior, (c) self-concept/image, the way an adolescent views themselves and how that might be different if they engaged in health risk behavior, (d) affect and emotions, (e) and self-efficacy, the perceived ability to enact the behaviors (Guillamo-Ramos et al., 2008).

Next, a set of five immediate determinants influence the translation of intention into ability to actually enact the behavior. These are (a) knowledge and skills for the performance of the behavior, (b) environmental constraints present that make enacting the behavior difficult, (c) the salience or importance of the behavior to the individual, and (d) habitual and automatic processes (Guillamo-Ramos et al., 2008).

In a study to test the validity of this framework, 668 middle school students from New York City were administered questionnaires. The population was 75% Latino and 25% African American. A link between behavioral intentions and behavior was found lending evidence to the validity of the model as a whole. The model is influential as it integrates the fundamental constructs of the five most popularly used models on health behavior into a single framework. (Guillamo-Ramos et al., 2008).

Determinants can be related to the individual, their perceptions of themselves and the situation, but people and institutions in the school can also affect sexual behavior and

contraceptive use and are important for the school counselor to know as well (Kirby, 2002a). These determinants are covered when counselor interventions strategies are detailed. It is important to note that there are limitations to what factors a school or school counselor can address. For example, schools have no influence on the onset of puberty, a biological factor related to onset of sex as well as other biological factors addressed in the section on adolescent development. Although these factors are unalterable in nature, a counselor can be aware of adolescents who display them and be considerate of the elevated risk associated. Additionally, a counselor may be limited in what they can address regarding the adolescent's sexual behaviors depending on the rules and regulations of their school district (Bradley et. al., 1999).

Chapter 3: Introduction to Counselor Intervention Strategies

Being in the schools, the counselor is in a prime setting to reduce the prevalence of sexual risk taking behaviors. Challenges that might be met in the community are corrected in the organized ongoing structure of the school. Adolescents are required to attend school, spending as much as 5400 hours there. Parents and family are also more accessible through the schools. A school has compatible goals and purposes of improving outcomes for students that also make it an ideal program delivery mechanism (Conyne, 2004). In this optimal setting, there are several possible ways for a school to have an impact on sexual risk taking behavior. Schools create an environment that discourages risk taking and increases interaction with adults who also discourage it. Schools are a large proponent in helping students plan for the future, higher education, and careers. Developing communication skills is an influential task of schools as well as improving student self esteem and sense of competence. Lastly and simply, schools reduce the amount of unsupervised time that adolescents could be spending engaging in sex (Kirby, 2002c).

This impact that a school can have can be implemented by the school counselor through preventative counseling strategies (Conyne, 2004). In the schools, counselors can intervene through their own direct work with students, groups, and even with parents or teachers utilizing preventative counseling strategies. These include education, skill building, enhancing student positive development, involving parents and families, and through creating or implementing sexual risk taking prevention programming.

In many cases, counselors are typically involved in counseling in a crisis situation or for remediation. As much time and effort needs to be directed to preventative counseling. Conyne defines prevention as “a goal for both everyday life and for service delivery, through which people become empowered to interact effectively and appropriately within varying levels of

systems … and in settings (individual, family, school, community, work). Preventive application can yield a reduction in the occurrence of new cases of a problem, in the duration and severity of incipient problems, and it can promote strengths and optimal human functioning (2004)." Preventative counseling is an integration of this definition of prevention into counseling.

Ethical Guidelines

In all of the intervention strategies discussed in this review, it is important to remember the ethical codes for counselors, especially those surrounding confidentiality. When discussing adolescent sexual risk taking behaviors, it may be unclear as to what behaviors are so harmful that confidentiality must be broken and parents notified. According to the American school counselor association, the following ethical guidelines related to this issue state:

> "A.2.b. [A professional school counselor] keeps information confidential unless disclosure is required to prevent clear and imminent danger to the student or others or when legal requirements demand that confidential information be revealed. Counselors will consult with appropriate professionals when in doubt as to the validity of an exception."
>
> "B.1.a. [A professional school counselor] respects the rights and responsibilities of parents/guardians for their children and endeavors to establish, as appropriate, a collaborative relationship with parents/guardians to facilitate the student's maximum development" (ASCA Delegate Assembly, 2004).

In summary, a school counselor faces the ethical dilemma to keep what an adolescent says confidential while also recognizing that parents have a legal right to know what is discussed. A counselor is required to notify the parent with or without a request according to ethical guideline A.2.b. However, there are no standards or benchmarks for measuring when a

situation is one of "clear and imminent danger." In regards to sexual risk taking behaviors, interpretation can vary widely. The literature has suggested that a school counselor answer requests by parents for information about counseling sessions, to provide some type of information but to not completely disclose all specific information, as that is not required. School counselors should use some discretion in the amount of information given and in how detailed the information is (Moyer & Sullivan, 2008).

In a survey, 2,000 randomly selected middle and high school ASCA members responded to a variety of risky behavior prompts. They were asked to rate the degree to which it was ethical to break confidentiality for each risky behavior on a 6 point Likert scale rating ranging from 1, unquestionably not ethical to break confidentiality, to 6, unquestionably ethical to break confidentiality. Results showed that counselors are less likely to find it necessary to break confidentiality for sexual risk taking behaviors. Examples of other behaviors measured were self-mutilation, substance use, antisocial behavior, and alcohol use. However, counselors did find it more ethical to report behavior if it was at a higher level of intensity and frequency/duration (Moyer & Sullivan, 2008). In the end, it is up to the professional judgment of the counselor, possibly with the assistance of consultation to judge each individual situation when confidentiality should be broken as they use the following preventative counseling interventions.

Chapter 4: Education

Education is the most frequently used strategy used in preventative counseling. However, attitudes, behaviors, and conditions surrounding the learner must also be addressed (Conye, 2004). Researchers have shown that addressing knowledge alone to increase contraceptive use or decrease sexual behaviors is ineffective and gaining knowledge on condom use or sexual health risks from educational programs has been shown to have either a weak or no association with condom use or preventing sex behaviors respectively (Ryan, Franzetta & Manlove, 2007). Instead, knowledge must be combined with other strategies like communication skills building to produce lasting and sustainable change (Gullotta & Adams, 2005; Conyne, 2004).

Nevertheless, education is an important strategy to be incorporated. Many adolescents don't know when they hold misconceptions about sex and contraception placing them at higher risk for pregnancy and STIs (Ryan, Franzetta & Manlove, 2007). In fact, only ¼ of 750 middle school and high school students answered 5 out of 5 questions correctly when given a "strong condom knowledge" test (Ryan et al., 2007). Adolescents must know how to use condoms correctly and consistently every time to be effective. However, before implementing the strategy of education, counselors must first look at the school's policies, their own values, and their sexual knowledge. These are covered next, followed by some guidelines to follow when implementing the education strategy.

School Policies

When discussing the controversial topic of sex, contraception, and the values surrounding it, educating adolescents outside of a school's adopted program must be done with caution. Before a school counselor can begin education their students on sex and pregnancy and STI prevention, they must first be aware that they are limited in the information they can give by the

policies and procedures of the school district. It is important to be familiar with them and to follow them, or one might meet with disciplinary action or even dismissal (Bradley et al., 1999). However, leadership can be undertaken to draft new policies or revise old ones. Bradley et. al. suggests starting a parent advisory committee of about 10 parents from varying socio-economic backgrounds, including both genders, and representing a range of values from conservative to liberal to participate in discussions about how they would like sensitive issues to be handled within the framework of school and legal policies (1999). If limiting policies exist, there is still much potential for a school counselor to educate students by focusing on coping with developmental needs, deciphering values and boundaries, communicating with parents, making decisions about sexual activity, unlearning negative behaviors and patterns, and recognizing and coping with dating abuse, sexual abuse, or rape (Bradley et al., 1999).

Personal Values

Sometimes, counselors feel anxiety about talking to adolescents about sex. This might come from their own experiences learning about sex as adolescents. However, to be an effective counselor, the topic cannot be avoided (Bradley et. al., 1999). Examining one's own values regarding sexual behavior and sexual orientation is important. The subject of sex can be a very value laden and often times religious thing for people, including counselors and their students. While one does not need to change their moral views on the subject of sex, one should practice perspective taking as there will likely be individuals with very different worldviews and know when to refer adolescents if values or religious orientation cause too much of a barrier (Bradley et. al., 1999).

Necessary Knowledge

In addition to needing to know the fundamentals of the reproductive systems and health of men and women, counselors should know the different bacterial and viral infections that can be transmitted through sex, the warning signs and symptoms of each, and the behaviors that are effective in preventing them. Several of the most common STIs have no signs or symptoms or only mild signs or symptoms and thus they can be easily overlooked leading to long-term damage. This fact, along with the lack of a clear medical problem is pare to of the reason many experts in public health have begun to replace the term sexually transmitted disease with sexually transmitted infection (STI). The viruses and bacteria that are transmitted can be described as crating an infection, which may or may not result in a disease (American Social Health Association, Inc., 2010). Because STIs often go unnoticed, it is also important for counselors to encourage sexually active persons to get tested regularly and to provide information on where and how to do so.

Counselors should also be knowledgeable about contraception including the different types, advantages and disadvantages, how to obtain them, and cost. These methods include barrier methods like the male and female condom, hormonally methods like oral contraceptives, the patch, or the vaginal ring, and intrauterine devices (Centers for Disease Control and Prevention, 2009). The male condom is the most likely method of contraception for adolescents to use due to its ready availability and low cost. The male condom is 85–98% effective at preventing pregnancy and is most effective when used consistently and correctly (Centers for Disease Control and Prevention, 2009). Many myths surround the use of contraception that can affect their use. If an adolescent were to have negative expectancies about contraceptives, for example a male who believes that condoms will decrease sensitivity and pleasure, or a female

who thinks that birth control will cause her to gain weight, they would be less likely to use contraception (Ryan, Franzetta & Manlove, 2007).

Lastly, it would be beneficial for counselors to have access to information about the norms of adolescent and sexual risk taking behaviors. Descriptive norms, as discussed in the theory on adolescent sexual risk taking behavior, describe how common the adolescent perceives the behavior to be among different peer groups (Guilamo-Ramos et al., 2008). The number one myth about sex for adolescents is that "everyone is doing it." The literature has shown that if adolescents simply believe that their peers are engaging in sex, even if they are not, they are more likely to have sex (Miller et al., 2005). As mentioned before less than half of adolescents in grades 9-12 have engaged in sexual intercourse (Trends in the Prevalence, n.d.) Busting this myth can be a huge educational strategy counselors can implement. A counselor can find more up to date information about reproductive health, STIs, contraception, and adolescent sexual risk taking behavior trends through resources from the Center for Disease Control, Planned Parenthood of America, or the American Social Health Association.

Guidelines

Once armed with the knowledge needed to provide the necessary psycho-education for adolescents within the policies of the school, counselors can follow some key guidelines laid out by Bradley et. al. to ensure optimal and effective responses to students' sexual development issues. First, it is important to normalize the experiences that adolescents are undergoing. This can be particularly helpful as an adolescent begins to experience the physical changes of development. Adolescents may need to be reassured that many experience anxiety over getting their period for the first time or having a wet dream. Also, it is normal to experience some ambivalence about whether or not to have sex. Often adolescents believe that everyone is having

sex but them. Normalizing developmental changes and the choices that go with them will ease an adolescent's concerns (Bradley et. al., 1999).

Conversely, it is also important to not minimize a student's personal experience. Adolescents are often experiencing their first kiss, first boyfriend or girlfriend, first love, and first sexual experience. They will lack the experience to put these situations in perspective. Yet to be effective, a counselor should not attempt to comfort the adolescent by minimizing the experience or putting it into perspective. Instead, it is best to acknowledge and empathize with the intensity of teen emotions (Bradley et. al., 1999).

One last guideline when beginning to address sex with adolescents is to be open, aware, and flexible. Counseling students one-on-one can be promising as students can present school counselors with their sexual issues (Bradley et. al., 1999), but often a student may feel uncomfortable broaching the topic with a counselor. Many are not likely to walk into a counselor's office and directly bring up the subject. They may indirectly verbalize concerns or "fish" for information about a counselor's opinions on sexual issues. They may indirectly try to gain information by asking about a news story, presenting a hypothetical situation, or asking the counselor how they feel about an issue. These interactions may be the way the student gauges if they can trust the counselor with more personal information. Also, meeting students on their own turf, in the cafeteria, at extracurricular activities, or even in the hallway, will help them see the counselor as approachable (Bradley et. al., 1999).

Chapter 5: Skill Building

An adolescent's skills are the individual's actual ability to enact the behavior as opposed to the perception of ability (Guillamo-Ramos et al., 2008). The relationship between perceived skills to resist sex and communicate about contraceptive use has received mixed conclusions. Some studies find a positive relationship, some no relationship, and some have even found a negative relationship (Ryan et al., 2007). Even if adolescents self identify as having skills to resist engaging in sexual risk taking behavior, the counseling intervention of skill building may still be necessary. Once again, using education alone to increase contraceptive use or decrease sexual behaviors is ineffective (Ryan, Franzetta & Manlove, 2007). Instead, knowledge must be combined with skill building. The skills that are most often addressed to reduce sexual risk taking behavior are decision-making, and communication skills for refusing sex and using contraception.

Decision-Making

When aiding an adolescent through the decision making process, a counselor teaches students how to make decisions, not what decisions to make. When considering sexual activity and contraceptive use, there are a number of critical steps to go through. Adolescents must have the relevant information, weigh the alternatives, and commit to the decision (Charles and Blum, 2008). Using the preventative counseling strategy of education provides the adolescents with the relevant information. Next, counselors should help adolescents weigh the alternatives, clarify their own sexual values, and decide what boundaries they want to set for themselves. Whether or not to engage in intercourse will be an important question for every adolescent to answer for himself or herself. Sometimes, adolescents have concerns about sexuality that they have trouble

verbalizing or identifying. A counselor needs to be skilled in assessing what concerns might be troubling the adolescent (Bradley et. al., 1999).

Bradley et. al. suggests the following group activity for adolescents for deciding what sexual behaviors they want and do not want to engage in. Questions about values and boundaries surrounding dating, sex, contraception, and dating violence are written on note cards and placed in a container. The individuals in the group pass the container around and take turns answering a question. The group then discusses the question and each student gives their own responses to the questions as well. The questions could also be used in an individual session as well. In this situation, listen as the individual weighs the pros and cons (1999).

It will be important to look at outside factors that may influence an adolescents decisions about sexual behaviors. The opinion of friends and parents may be discussed. Also, in cognitive behavioral substance abuse prevention curriculum, students are taught about advertising and media influences that can affect their decision-making. (Galassi & Akos, 2007). This aspect can also be a part of sexual risk prevention. Depictions of sex abound in the media but there are also mediums that offer a warning such as the television program "16 and Pregnant." The music, books, television shows, movies, and magazines that an adolescent likes and the medium's depictions of sex should be discussed with the adolescent when considering and adolescents decision on sexual activity.

After weighing the alternatives the student commits to the behavior. However, even if an adolescent has set boundaries for themselves, they must still follow through on these decisions in situations that are sometimes stressful or even volatile. Preparing adolescents to exercise self-restraint, impulse control, and emotional regulation is important not just for committing to decisions about sexual activity but also for their personal and social development (Charles &

Blum, 2008; Galassi & Akos, 2007). A lack of ability to self regulate emotions is related to an increase a variety of sexual risk taking behaviors and a lack of self restraint has been shown to have a correlation with an increased number of sexual partners (Charles & Blum, 2008).

Other factors can influence an adolescent's commitment to behavior. Adolescents may have developed habitual or automatic responses when in a situation involving sex. For example, an adolescent who has decided to use contraceptives consistently fails to do so when having sex with a partner in which contraceptives were previously never used in the relationship (Guillamo-Ramos et al., 2008). In addition, drugs and alcohol impair an adolescent's ability to make decisions or remain vigilant in their choices. Adolescents should be prepared in how substances can cause them to disregard their choices and thus should be avoided. Helping adolescents commit to their decisions about sex and contraception can be achieved through communication skill building.

Communication Skills For Refusing Sex and Using Contraception

Today's adolescents are faced with a variety of instances where the need for social and communication skills is imperative for their success. A lack of these skills seems to permeate a variety of high risk behaviors including violence, poor peer relationships, and suicide (Thompson, 2002). Social and communication skills surrounding sex are often underdeveloped in adolescents resulting in communication about sex being difficult and awkward for adolescents. In our culture, sex is frequently joked about but serious conversations are more rare. Social skills that can promote positive interactions about sex (and in all situations) that can be developed in adolescents include conveying your message clearly and assertively, listening more effectively, and negotiating a conflict (Thompson, 2002).

Teens will need practice in developing the skills to communicate a preference to wait or an expectation for using contraception (Hatcher, Colestock, Pluhar & Thrasher, 2001). Advise adolescents to talk with their partners about their values, boundaries, and expectations. Their messages should include making clear requests and listening to the other's views. Nonverbal communication through eye contact, facial expressions, tone of voice, and gestures should all be stressed to adolescents as additional channels through which they can effectively and consistently communicate their message (Thompson, 2002). Help adolescents to understand that the best time for a conversation about sex and contraception is in a relaxed, calm environment; not in the heat of the moment.

It may occur that an adolescent has decided to be sexually active. For this reason, skills must also be developed for respectfully initiating sex. Educate teens on why they should not pressure their partner or their peers to engage in sex and build their skills in recognizing when coercion is happening. Pressure may be direct to encourage someone to engage in sex or it may be indirectly pressure when someone who has not had sex is embarrassed or someone who has is glorified (Bradley et. al., 1999). Another part of respectfully initiating sex is to be prepared with a contraceptive method. A counselor can encourage adolescents to be prepared with contraception. Females and males alike can purchase and carry condoms. Adolescents should know where and how to purchase contraceptives and perhaps can even be encouraged to practice doing so.

In an adolescent's discussion with their partner about their sexual decisions, it may occur that there is an incongruence in the decisions of each partner about if they would like to have sex or use contraception. Thus, skills for successfully navigating conflict and resisting pressure should be developed. Help teens to develop responses to a partner pressuring them to have sex or

not use contraception. Have them practice responses until the adolescent is comfortable and assertive in using the responses. For example, when a partner says “if you really loved me, you would have sex with me.” A response that reverses the pressure would be “If you really loved me, you wouldn’t pressure me to have sex with you.” Some partners may insist that sex with a condom is not pleasurable. A response that reverses the pressure would address that without a condom, there won’t be an sex, and that will be even less pleasurable (Hatcher et al., 2001; Bradley et. al., 1999). Another activity involves adolescents coming up with a list of alternatives to sex that they can then recommend to a partner as an alternative way to achieve intimacy and closeness (Bradley et. al., 1999). Lastly, one can recommend that adolescents develop a safe word with their partners. This safe word means that the physical activities or discussions are past one’s boundaries. Partners agree that when this safe word is used, the undesired behavior or discussion is stopped. This can be helpful to explicitly communicate a boundary when words like “come on, stop it” or even “no” can be interpreted differently based on tone of voice, nonverbal behaviors, or lack of a physical cue to stop (Hatcher et al., 2001).

Chapter 6: Enhancing Student Development

Many researchers have found that promoting positive development in students increases protective factors for all areas of risk for students, not just sexual risk. This is because many problems related to youth development have many of the same protective and risk factors (Conyne, 2004). To detail all of these and the ways in which counselors can enhance their development would be too much information for this review. However, there are some well-documented protective factors that counselors are capable of addressing and are often of importance and consideration in a counseling program regardless. This review will look at the effects of self-concept, pro-social connectedness, and emotional well-being.

Self-concept

When factors of self-concept combine to lead to a positive sense of self, they can contribute to the prevention of sexual risk taking behaviors. Self-esteem has been frequently examined for its relationship with sexual debut and contraceptive use. Research shows that higher levels of self-esteem are related to lower intentions to engage in sexual intercourse as well as safer sexual behaviors (Charles & Blum, 2008; Guilamo-Ramos et al., 2008). Other studies have found that self-esteem has a different impact on sexual behavior depending on gender. For females, lower self-esteem is associated with an earlier onset of sexual intercourse, whereas for males higher self-esteem leads to an earlier onset (Brendgen et al., 2007).

Self-concept also includes how individuals would feel about themselves if they were to engage in sexual behaviors (Guilamo-Ramos et al., 2008). An adolescent is more likely to engage in sex if they hold beliefs that the social prototype of someone who is sexually active also holds positive attributes of popularity. Conversely, adolescents are less likely to engage in sex if

they associate the negative attributes of low morals and irresponsibility to the social prototype (Guillamo-Ramos et al., 2008). The two aspects of self-concept are also related, for as self esteem decreases, the adolescent will be more likely to engage in behaviors that they feel will give them a more positive image (Guilamo-Ramos et al., 2008).

Finally, self-efficacy, a construct of self-concept is related to adolescents' sexual risk taking behaviors. As mentioned before the relationship between perceived self efficacy to resist sex and communicate about and use has received mixed conclusions. Some studies find a positive relationship, some no relationship, and some have even found a negative relationship (Ryan et al., 2007).

Pro-Social Connectedness

Pro-social connectedness describes how connected adolescents are to parents, peers, romantic partners, schools, neighborhoods, and communities. The more connected an individual is, the less likely they are to engage in sexual risk taking behaviors (Charles & Blum, 2008). The relationship with parents is so influential that it is discussed in a separate section: involving parents and families.

Connectedness with peers can be either protective or risky. Commonly, perceptions of approval from peers positively affect intentions to engage in sex where as disapproval from peers has a negative relationship (Charles & Blum, 2008; Guilamo-Ramos et al., 2008). This negative relationship is especially true of adolescents who socialize with a group of peers who engage in other delinquent activities. These adolescents are seen to be at a higher risk because of the acceptance of such behaviors (Miller et al., 2005). In regards to romantic partners, a lack of intimate feelings for their partner has been correlated with less contraceptive use (Ryan et al., 2007).

Pro-social connectedness to school can include investment in school, school involvement, and school performance. All of these negatively affect age of initiation, frequency of sex, pregnancy and childbearing (Charles and Blum, 2008; Kirby, 2002c). Regular attendance, good grades, plans for higher education after high school and an overall valuing of education as important all have effects of postponing sex and increasing the frequency of contraceptive use (Kirby, 2002a, Kirby, 2002c; Miller et al., 2005). Research has found a direct causal impact for students who have dropped out of school and earlier onset of sexual debut, failure to use contraception, increase pregnancy rate, and increased birth rate (Kirby, 2002c). Plans to attend college also delay initiation, increase use of condoms and contraception, and reduce pregnancy and childbearing (Kirby, 2002c). Finally, extracurricular activities have been shown to have similar protective effects for females (Miller et al., 2005).-

By having school programs aimed at keeping students from dropping out and increase attachment to school, sex can be delayed and the pregnancy rate reduced (Kirby, 2002c). Other non-sexuality focused school programs have also been shown to have an effect on sexual onset and contraceptive use. Service learning programs include voluntary service in the community with time for preparation and reflection. These programs can increase attachment to school and reduce school failure, which have an indirect effect on sexual risk taking behaviors (Kirby, 2002b, 2002c). There are some service-learning programs that also involve a sexual health component. Research has found that these directly prevent pregnancy and STIs in both the short and long term (Charles & Blum, 2008).

Emotional Wellbeing

Most factors that have been discussed thus far have been cognitive in nature. Emotions are different from in that they can be intense and short-lived (Guillamo-Ramos et al., 2008). Arousal and the positivity or negativity of that arousal are two aspects of this determinant. Generally, a strong positive arousal about a behavior will lead to its enactment and a strong negative arousal about a behavior will lead to its avoidance (Guillamo-Ramos et al., 2008). Counselors can use previous strategies to reverse the trajectory of an arousal or emotional response that can lead to sexual risk taking behaviors as well as create a positive arousal and emotional response for delaying sex and using contraception.

As noted before, early onset of sex is considered to be an observable indicator of depression. Depression has also been linked to lower contraceptive use in females and males (Sabia, 2006). Part of a counselor's responsibility to their students is to address the emotional needs of students and recognize students who may be suffering from depression. Counselors should know that these students may be at high risk ad assess for possible sexual risk taking behaviors. Addressing emotional wellbeing in everyday work with students leads to prevention.

Chapter 7: Involving Parents and Families

One of the most powerful influences on teen's sexual behaviors is their parents. When surveyed, 47% of 12 to 14 year olds said the source that provided the most influence on their sexual decisions was their parents. Also, 87% said that if parents were more communicative with them about sex, contraception, and pregnancy, it would be easier to postpone sex and avoid pregnancy (Lederman et al., 2008). When an adolescent presents with concerns about sex and contraceptives, the first step for a school counselor would be to defer to the parents when a student presents with questions about sex. If a school counselor is concerned about a student possibly having an unsafe sexual relationship, they may ask if the student has talked with their parents about issues surrounding sex and sexual risk taking behaviors.

There are also programs that can be initiated that involve parents in prevention education. Studies have shown that such interventions can have a positive effect on parent child communication, and the child's knowledge and attitudes on sex (Lederman et al., 2008). In one program entitled Parent and Adolescent Relationship Education (PARE), parents and their 3,881 middle-school adolescents participated in a well-designed interactive program encouraging communication that included role-plays, practice exercises, and parent-child discussions. When compared with an intervention that had the same content but was delivered in a traditional didactic format, the interactive format was found to be more effective for strengthening social and self controls to reduce risks for adolescent pregnancy and STIs, increasing social control through parent rules, and enhancing adolescent self controls through increased knowledge about prevention and skills related to resisting pressures to have sex (Lederman et al., 2008).

This study as well as past studies has found that an increase in the amount of parent-child communication about sex does not have a strong correlation with decreased risk. However,

studies have shown that the content can be very important in influencing adolescent decisions to remain abstinent or to exercise safer sex practices if they do become sexually active. In fact, specific messages by the parents can cause one behavior over the other. Research shows that a relationship identified by the adolescent as warm and caring will delay the debut of sexual initiation. Aspy et. al. also showed after controlling for demographic factors that parents talking about what is right and wrong in sexual behavior, communicating delaying sexual activity, and providing clear rules were correlated with adolescents remaining abstinent (Aspy et al., 2007; Lederman et al., 2008). Commonly, perceptions of approval from peers positively effects intentions to engage in sex where as disapproval from parents has a negative relationship (Guilamo-Ramos et al., 2008). Communication about the use of birth control and preventing STIs has an adverse effect on prevention of sexual activity. The reason for this is unknown as it may be that parents who choose talk about these subjects with their children may be advertently or inadvertently giving permission to engage in safe sex or if they are recognizing their child's need based on pending or current sexual activity (Aspy et al., 2007). Although talking about birth control and STI prevention increases the likelihood of sexual activity, many research findings have also shown that it also increases the likelihood to actually use birth control (Aspy et al., 2007). Interventions with parents can thus focus less on the quantity of the communication between adolescents and their parents and more on the content that is covered. Adolescents need to know their parents' opinions about having delaying sex and about the parents' rules surrounding social behaviors to prevent sexual behavior and parents need to discuss birth control and STI prevention to increase contraceptive use (Aspy et al., 2007; Lederman et al., 2008). This research seems to force parents into making a decision about what would be more important, preventing abstinence or promoting contraceptive use.

Counselors should encourage their students to have a discussion about these topics with parents. Prevention programming that targets creating effective communication between parents and adolescents has also been shown to reduce sexual risk taking behaviors (Aspy et al., 2007). Finally, a counselor may also teach and offer resources to parents about how to have these conversations with their children clearly and explicitly should a program to address parent-child communication about risk behaviors be unfeasible (Aspy et al., 2007). Many resources are available on this topic and many can be easily accessed over the Internet, but there is no research on the efficacy of any particular book, handout, or website in improving parent-child communication or decreasing sexual risk taking behaviors.

Counselors must use their own judgments as to what resources to recommend as there is little research for materials outside of planned programming. Many resources are available and the spectrum ranges from official agencies like "The National Campaign to prevent Teen and Unplanned Pregnancy" has a portal for parents and resources on how to talk with their teen (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2010) to TV Personality Oprah Winfrey's advice from Dr. Laura Berman about the topic with a handbook called "The Sex Ed Handbook: A Comprehensive Guide For Parents" (Berman, nd).

Chapter 8: Implementing Programs

Varying intervention programs have been shown to have an impact on a variety of adolescent sexual risk taking behaviors. However, a debate currently exists surrounding the appropriateness and efficacy of these interventions (Jemmott et al., 2010). Most youth receive some amount of sex education but many topics remain uncovered (Kirby, 2002c). Some have speculated that sex and HIV education programs will increase sexual behavior, but these programs have been found to neither cause adolescents to initiate sex earlier, have more partners, nor increase frequency (Kirby, 2002b; 2002c). Others postulate that abstinence only education programs will unintentionally cause a decrease in use of condoms if the adolescents do have sexual intercourse. These effects have also been found to be non-existent (Jemmott et al., 2010). The debate that currently holds our country divides sex education programs into two categories. Abstinence-only programs are curricula that encourage only abstinence (Kirby, 2008). Some abstinence only programs may include some information about contraceptives, but do not encourage their use. Some of these exaggerate their failure (Kirby, 2008). For example, condoms are often understated as having a very low efficacy rate. However, this rate describes the efficacy of condoms when used as a method and includes times when the consumer uses the condom incorrectly and when they forget to use it. When condoms are used consistently and correctly every time, the efficacy rate jumps to 98% ("UHS Condoms," 2008). Comprehensive programs also support abstinence as the safest way to prevent pregnancy and STIs but also recommend condoms and contraception (Kirby, 2008).

Researcher Douglas Kirby reviewed 56 studies that assessed the impact of abstinence-only curricula and comprehensive sex curricula (2008). His rigorous criteria and through analysis of the studies available make his review extremely useful to the debate on sex education

programs and provide a partial, but not final, answer. Many studies that are used as evidence for either side are often poorly designed and do not meet standards for scientific evidence. Kirby's criteria for inclusion in the review were that the sex education program must have: (a) been a curriculum and group based program, (b) focused primarily on sexual behavior, (c) focused on middle school and high school students, (d) been implemented in the United States. In addition, the research study must have: (e) had a strong experimental or quasi-experimental design, (f) had a sample size of at least 100, (g) measured impact on one or more sexual behaviors including initiation of sex, frequency of sex, number of partners, use of condoms or contraceptives, composite measures of sexual risk (e.g., frequency of unprotected sex), pregnancy rates, birth rates, and STI rates, (h) measured impact of program on behaviors that can change quickly for at least 3 months and on behaviors that change slowly for at least 6 months, (i) and was completed after 1990 (Kirby, 2008).

Since not many programs or research studies meet the criteria set out by Kirby, only 9 abstinence programs are available to be evaluated. Included in these 9 programs are two longitudinal, rigorous experimental studies that evaluated programs that also met federal guidelines to receive funding. These studies found that the programs had no impact on sexual behaviors (Kirby, 2008). Of all the studies, only two found that the program succeeded in delaying onset of sex, two found that the program decreased frequency of sex, and one found that the program reduced the number of sexual partners (Kirby, 2008). Conversely, 48 studies were researched that covered 32 different comprehensive and STI/HIV programs. Of these programs that measured the applicable construct, 47% delayed the initiation of sex, 46% reduced the number of sexual partners, 47% increased condom use, 44% increased contraceptive use, and 29% reduced the frequency of sex (Kirby, 2008). However, one program was found to increase

sexual partners and one was found to decrease contraceptive use. Nevertheless, the results provide strong evidence that comprehensive and STI/HIV sex education programs are more effective at reducing a variety of sexual risk taking behaviors (Kirby, 2008).

Since Kirby's review of sex education programs available, there has been a new study released in February of 2010 that has begun the process of gaining back some efficacy for the abstinence-only programs. Jemmott, Jemmott, and Fong have conducted a study measuring the effectiveness of abstinence-only, safer sex-only, comprehensive interventions (8 hour and 12 hour intervention), and a health promotion control intervention on sexual initiation, recent sexual activity, multiple partners, and condom usage recently and consistently (Jemmott et al., 2010).

The abstinence only intervention succeeded in reducing sexual initiation from an estimated 48.5% in the health promotion control group to 33.5%. The study found that safer sex-only and comprehensive interventions did not differ from the control group. The abstinence intervention also significantly reduced recent sexual intercourse (in the past 3 months) from 29% in the control group to 20.6%. The 12 hour comprehensive intervention only showed a marginally significant difference form the control group. Conversely, 8 hour and 12 hour comprehensive interventions showed a significant difference in likeliness to have multiple partners (8.8% and 8.6% respectively) than those in the control group (14.1%) (Jemmott et al., 2010). Although no statistically significant effect on any of the programs on condom use was found, the small number of sexually active adolescents rendered the ability to statistically test the effects on condom use severely limited.

Although this research represents a huge step for the efficacy of abstinence-only education, there are some limitations to this study. First, the program was not designed with federal criteria for abstinence only programs in mind. The ways in which the program differed

from federal criteria are as follows: (1) target behavior was to abstain from vaginal, oral, and anal sexual behaviors until a later time in life when adolescents could better handle the consequences as opposed to until marriage, (2) it did not have a moralistic tone, (3) and it did not disparage the use of condoms nor stress their ineffectiveness. Facilitators were instructed to correct any voiced opinion that condoms were ineffective. Although not required by the federal programs, the program evaluated in this report also differed from other abstinence-only programs in that it did not portray sexy in a negative light (Jemmott et al., 2010). Because of all these differences, the researchers caution against generalizing the results too broadly. They do not mean that all abstinence only intervention will work, that abstinence only interventions are the best approaches, nor do the results mean that other approaches should be abandoned (Jemmott et al., 2010). Lastly, because this study was conducted on African American 6th and 7th graders, the generalizability to older adolescents of other races is unclear (Jemmott et al., 2010).

Preventing adolescent sexual risk taking behaviors requires an array of approaches (Jemmott et al., 2010). Theory based Abstinence-only interventions may work with younger adolescents whereas older adolescents in high school my benefit from interventions that have been proven efficacious with their specific age group. In conclusion, the following characteristics have been identified across the research as components of an effective sex education program: targets a specific age range, program is lasts at least 14 hours, trained educators deliver curricula, interactive activities to engage students, based on theoretical approaches, gave a clear and reinforced message about sexual activity and/or contraceptive use, provided information about risks and reality of teen pregnancy and STIs, focused on modeling and practice of communication, negotiation, and refusal skills, addressed peer pressure, and were age, sexual experience, and culture sensitive (Miller et al., 2005; Abel & Greco, 2007; Kirby, 2002b).

Conclusion

When an adolescent decides to raise a child, they become at risk for a variety of subsequent problems. Poverty, health risks for mother and child, insufficient health care, inadequate parenting, physical and sexual abuse, lowered likelihood of earning a high school diploma for the mother, and school difficulties for the child are all examples cited by the research (Campos, 2002; Gullotta & Adams, 2005). Sexually transmitted infections can result in the need for lifetime maintenance as well as more permanent infections or diseases when left untreated like pelvic inflammatory disease, infertility, ectopic pregnancy, cancer, and in extreme cases death as with HIV and AIDS (Hatcher et. al., 2001). These situations serve as strong evidence for our need to prevent sexual risk taking behaviors. However, it is important to prevent these behaviors for even the least impactful consequences, because they are unhealthy and dangerous for adolescents at every level.

In this review, it was determined that sexual development is normal for adolescents and not problematic (Walcott et al., 2008; Brendgen et al., 2007). However, early pubertal development has been shown to be a predictor for early involvement in intimate relationships, ideation of sex, onset of sex, increased number of sexual partners, and level of sexual involvement two years later (Gullotta & Adams, 2005). Sexual intercourse does not have a negative impact on adolescent's wellbeing unless done at an early onset (ages 10-14), in which risk of increased number of partners, sex with high risk partners, pregnancy, STI transmission, and negative effects on academics increases (Brendgen et al., 2007; Guillamo-Ramos et al., 2008; Sabia, 2006). Lastly, the inability of adolescents to make informed decisions due to their still developing cognitive abilities was discussed (Sylwester, 2007).

The conceptual framework detailed by Guillamo-Ramos et al. aided in the understanding of the decisions adolescents make about engaging in sex and using contraceptives. The proximal determinants influencing behavioral intention were expectancies, social norms, self-concept/image, affect and emotions, and self-efficacy. The immediate determinants that influenced the translation of intention into enacting the behaviors were knowledge and skills, environmental constraints, salience of the behavior, and habitual or automatic responses (Guillamo-Ramos et al., 2008). A school counselor can address these determinants in their interventions with adolescents to help reduce intention and enactment of behaviors.

In implementing prevention and intervention, the importance of upholding ethical guidelines is imperative. In a survey of 2,000 ASCA members, counselors were found to be less likely to find sexual risk taking behaviors as clear and imminent dangers requiring the breaking of confidentiality. The researchers of this survey suggest that a school counselor should provide some information to parents but should not completely disclose all specific information and use discretion when considering breaking confidentiality (Moyer & Sullivan, 2008).

Some of the most researched and effective counseling strategies were presented in this literature review. They were education, skill building, enhancing student development, involving parents and families, and implementing programs. Considerations and recommendations for the implementation of each were given. Education, the most widely used strategy, requires much preparation and self-reflection on the counselor's part before it can be implemented. Reviewing the school policies, assessing personal values, and gaining the necessary knowledge will ensure the success of this strategy (Bradley et al., 1999). However, education alone has been shown to be ineffective without the additional strategies (Ryan et al., 2007). Guidelines for the implementation of the education strategy stressed the importance of normalizing the experience,

avoiding minimizing the experience, and being open, aware, and flexible in addressing sex (Bradley et al., 1999).

The second counseling strategy addressed is skill building. Decision-making and communication skills have both received credit by the research as reducing unprotected sex (Kirby, 2002b; Kirby, 2002c). School counselors can help adolescents proceed through the steps of the decision making process. Adolescents must have the relevant information, weigh the alternatives, and commit to the decision (Charles & Blum, 2008). Activities for helping adolescents determine their own boundaries within their social context are suggested followed by considerations for helping adolescents commit to their decision despite emotions, habitual or automatic responses, and possible substance use. Activities and considerations for developing communication skills and refusal skills are also covered. Practice is needed to ensure adolescents can communicate their message clearly and respectfully, can navigate conflict, and can assertively resist pressure (Bradley et al., 2001; Hatcher et al., 2001; Thompson, 2002).

Promoting positive development in students is an integral part of the counselor's professional role in the school and increases protective factors for students in all areas of risk (Conyne, 2004). Three well-researched protective factors are detailed. The first, self-concept includes factors such as self-esteem and self-efficacy that can be developed in the adolescent. When adolescents have low self-esteem, they are more likely to engage in behaviors that they feel will give them a more positive image (Guillamo-Ramos et al., 2008). However, adolescent's perceived self-efficacy at resisting sex and using contraceptives has received mixed conclusions (Ryan et al., 2007). The second factor to be addressed in promoting positive development was pro social connectedness, which describes how the more connected adolescents are to their parents, peers, romantic partners, schools, and communities, the less likely they are to engage in

sexual risk taking (Charles & Blum, 2008). Connectedness to peers can have a protective or risk elevating influence depending on the group. Peers who engage in delinquent activities and who are accepting of high-risk behaviors like engaging in sex can create elevated risk. Emotional connectedness to the romantic partner can influence increased contraceptive use. Finally, a myriad of connections to school have been shown to postpone sex and increase contraceptive frequency (Kirby, 2002c; Miller et al., 2005). Lastly, emotional wellbeing of adolescents should be considered as higher levels of depression or stress is an antecedent of initiation of sex and failure to use of contraceptives (Kirby, 2002a.). An adolescent's emotions surrounding sex and contraception should also be considered as a high-negative arousal can result in enacting risk behavior (Guillamo-Ramos et al., 2008).

Involving parents and families, the fourth strategy, had proven to be a powerful preventative strategy as 87% of students felt parental communication would make it easier for them to postpone sex and avoid pregnancy. Parents must first be recommended as resources to adolescents who have questions about sex. It is effective to preparing parents to be this resource by providing educational tools or programs that involve them (Lederman et al., 2008). The messages that parents give can be very influential on behavior. Communication about birth control and preventing STIs has an adverse effect on preventing sexual activity but increases likelihood to use birth control (Lederman et al., 2008). More research may be needed to better understand this conundrum, for parents might need to choose which is more important, delaying sex, or preventing risk behavior. Across the research though, it is shown that parents need to convey their opinions and values on delaying sex and communicate clear rules, and develop warm and caring relationships to delay initiation of sex (Aspy et al., 2007, Lederman et al., 2008).

The last strategy a school counselor can use to reduce sexual risk taking is to advocate for or implement a validated educational program in their school. Although most youth receive some sex education, many topics remain uncovered (Kirby, 2002c). In a review of 56 studies assessing a variety of abstinence only and comprehensive sex education curricula, it was found that of those studies that met criteria for review, only two out of nine abstinence only curricula were found to delay onset of sex and decrease frequency of sex and only one was effective at reducing the number of sexual partners. A higher percentage of the comprehensive curricula reviewed were found to be more effective at delaying sex, reducing the frequency of sex, and reducing the number of sexual partners: 47%, 29%, and 46% respectively. Forty-seven percent of programs were also effective at increasing condom use, and 44% at increasing contraceptive use (Kirby, 2008). Even recent studies on abstinence only programs have failed to show that they are more effective at preventing risk behaviors. A recent study by Jemmott et al. (2010) showed reduction in sexual initiation, but the program did not meet federal criteria for an abstinence program that would have been funded by the government, and its population was limited to African Americans in the 6th and 7th grades.

In conclusion, there are a variety of strategies for the school counselor to implement in their school to help prevent the sexual risk taking behaviors of adolescents and the undesirable consequences of pregnancy and sexually transmitted infections that could result. Policies of the school, must be considered with any of these interventions as this topic can continue to be controversial despite evidence of the effectiveness of the strategies. In using these recommendations, the rate of teen pregnancy and adolescents affected by sexually transmitted infections may continue to decrease and more teens and their families will be able to live healthy lives and focus on future goals.

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