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AN ABSTRACT OF THE THESIS OF Russel Douglas Robbins for the Master of Science
in Teaching presented July 16, 1991.

Title: A Descriptive Study of Sexual Health Attitudes and Practices Among Adolescent
and Young Adult Male County Health Department Clients.

APPROVED BY THE MEMBERS OF THE THESIS COMMITTEE:


Dawn Graff-Haight, Chair


Leslie McBride


Judith Sobel


Eugene Hakanson

The purpose of this study is to look at selected sexual attitudes, beliefs, and sexual health practices among adolescent and young adult males. Specifically, the study examines adolescent and young adult males' sexual development and experiences, contraceptive use, sexually transmitted disease (STD) prevention practices, and, to a limited extent, public health clinic utilization.

The subjects ($n = 125$) were all males age 15 to 40, who came into the Clackamas County Health Department for their own appointment or accompanying a sexual partner. Subjects were asked to fill out the Men's Health Questionnaire, a 48-item questionnaire covering the aforementioned topics.

The results of the Men's Health Questionnaire showed that the males examined in Clackamas County are similar to males elsewhere in the United States. The average age of first intercourse in this population of males is 14.8 years old, with 54.2 percent experiencing intercourse for the first time between the ages of 13 and 16. As is also typical of United States males, 58.8 percent of the participants in this study are having sex with multiple partners in the last year. Of the males who indicated they had had more than one sexual partner ($n = 78$), 24.3 percent of them had had five sexual partners in the last year. The lifetime number of sexual partners for 34.3 percent of the participants was 6 to 10. Another 12.8 percent had 11 to 20 sexual partners; 19.2 percent had 21 to 50 sexual partners; and 12.8 percent had more than 50 lifetime sexual partners. In addition, over a third (38.5%) of these males reported having had an STD and 85.9 percent reported sometimes or never protecting themselves from their partner's bodily secretions. The number of males who used condoms was reported to be 78.3 percent of the sample, although only 14.0 percent said they always used protection.

These findings indicate expanded efforts in sexuality education are needed in this population. These efforts need to include comprehensive information on sexual development, initiation into sexual activity, and contraceptive and STD prevention practices.

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The results showed that the males examined in Clackamas County are similar to males elsewhere in the United States. These males have experienced sexual relations; they have had sex with multiple partners; they have sex frequently; and they do not use contraceptives or use protection for STDs. The implications of these findings indicate that expanded efforts in sexuality education are very much needed in this population.

A DESCRIPTIVE STUDY OF SEXUAL HEALTH ATTITUDES AND PRACTICES
AMONG ADOLESCENT AND YOUNG ADULT MALE
COUNTY HEALTH DEPARTMENT CLIENTS

by

RUSSEL DOUGLAS ROBBINS

A thesis submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE IN TEACHING
in
HEALTH EDUCATION

Portland State University

1991

TO THE OFFICE OF GRADUATE STUDIES:

The members of the Committee approve the thesis of Russel Douglas Robbins
presented July 16, 1991.


Dawn Graff-Haight, Chair

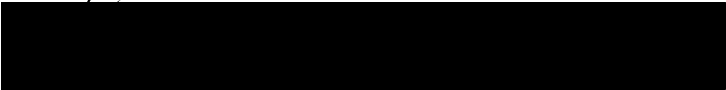

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DEDICATION

This project is dedicated to all males who desire a greater understanding of their sexuality.

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I would like to thank my thesis advisor, Dr. Dawn Graff-Haight, for her guidance, direction, and constant support on this project. I appreciate the time and effort.

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CHAPTER I

INTRODUCTION

BACKGROUND

Male sexuality is a topic that very few males fully understand. While many males of various ages have some knowledge about various topics in sexuality, much of this knowledge is replete with inaccurate information (Atwood and Gagnon, 1987). In fact, 20 percent of males do not even know what contraceptives are (Zelnik and Shah, 1983). It is also known that males are sexually active. By age 17, 50 percent of males have had a sexual encounter (Zelnik and Shah, 1983). Only 25 percent of the sexual encounters were planned, and when planned, only 30 percent of the encounters include the use of contraceptives (Westney, Cole, and Munford, 1986).

Evidence of this sexual activity can be seen in the fact that 75 percent of all reported cases of STDs are found in adolescent and young adults ages 15 to 24 (Manning, 1989). This is not surprising given the fact that 20 percent of 15 to 19 year old males have had three or more sexual partners in just the last year ("Number of Sexual Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988).

This study attempts to gain additional information regarding male sexual experience, contraceptive use, sexually transmitted disease (STD) prevention practices, and to a limited extent, public health clinic utilization.

STATEMENT OF THE PROBLEM

The problems that are associated with sexually transmitted diseases and pregnancies in the teenaged population are largely the result of ignorance. This ignorance can be attribute to a failure to provide current, accurate, comprehensive information about these two problems.

Young males are being forgotten in the process of addressing the high rates of teenage pregnancy and sexually transmitted diseases. Precautions to prevent both pregnancy and sexually transmitted diseases cannot be taken by young males left out of this process.

PURPOSE OF STUDY

The purpose of this study is to assess the sexual health practices and needs of males who visited the Clackamas County Health Department who responded to a 48-question, self-administered questionnaire on men's sexual health practices.

This project identifies the characteristics that apply to the population of males served and educated by the Clackamas County Public Health Department. With the information provided by the survey questionnaire, Clackamas County can better determine what kind of services young men need. Meeting the reproductive health needs of young males in Clackamas County may result in a decrease of both teen pregnancies and STDs.

Since this is not an experimental study, no cause and effect relationship was examined.

NEED FOR STUDY

Male sexual experience is beginning at an early age even compared with 10 or 15 years ago (Story, 1985). By the age of 15, 37.3 percent of males have had sexual intercourse; by age 17, 49.9 percent of males have had sexual intercourse; and by age 21, more than 80 percent of males have had sexual intercourse (Zelnik and Shah, 1983). It also appears that only about 25 percent of sexual encounters are planned, and that of all the encounters, only 30 percent involve the use of some form of birth control (Westney, Cole, and Munford, 1986). About 20 percent of both males and females do not even know about contraceptives (Zelnik and Shah, 1983).

The majority of research and services in the area of reproductive health issues have been directed toward females. This may be due to the fact that females are in the position of not being able to hide from the reality of an unplanned pregnancy. Males have been relatively forgotten, mostly because of the myth that they "do not want to be involved after a pregnancy has occurred." Research by Westney, Cole, and Munford (1986) has indicated that only a small percentage of males are not interested in helping take care of their child. While the majority of males report that they would rather wait until they are older to have children, they are still willing to remain involved in child care.

According to Manning, Barenber, Gallese, and Rice (1989), 75 percent of all cases of STDs are found in young people ages 15-24. In light of the fact that STDs are very common in this population, it is not surprising to learn that teenagers and young adults are having frequent sexual contacts with casual acquaintances, as well as sex with multiple partners. Twenty percent of teenagers aged 15 to 19 have had sex with three

or more partners in the last year ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988).

Of the total number of reported cases of Acquired Immune Deficiency Syndrome (AIDS) in the United States, 21 percent are found in males 20 to 29 years old. Since the mean incubation period from infection to illness is estimated to be 10 years, most of these young men were likely infected between the ages of 10 and 19 (Greespan and Castro, 1990). This is a compelling reason for young male sexuality education. Research indicates that five percent of 13 to 15 year old boys and 17 percent of 16 to 19 year old boys have reported having had at least one homosexual experience. In addition, 20 percent of the male population is bisexual (Remafedi, 1987). These facts lead one to the conclusion that a large number of young males are at risk for infection with Human Immunodeficiency Virus (HIV). Consequently, there is the potential for a large number of young females becoming infected. For this reason, sexuality education is urgently needed for the young male population.

LIMITATIONS

The study involved the following limitations:

1. The data used in this study were existing data collected by Clackamas County Health Department.
2. The study population was derived by attempting to ask all males who entered the clinic to fill out a questionnaire. It is not known if the completed questionnaires are representative of the total number of males who came into the clinic. This will be discussed further in Chapter III.

3. The information obtained can only be generalized to males who decided to be seen at the Clackamas County Health Department. These males are mostly blue collar workers, of whom 95.6 percent have been seen at the Health Department in the past for STDs.

4. Due to the personal nature of the subject matter, accuracy of the self-reported information may be limited.

RESEARCH QUESTIONS

Demographics

What are the demographics of the males who completed the Men's Health Questionnaire at the Clackamas County Health Department?

Sexual Attitudes and Beliefs

What are the sexual attitudes and beliefs of the males who completed the Men's Health Questionnaire regarding contraceptives and their use, and sexually transmitted diseases?

Sexual Experiences and Practices

What are the sexual experiences and practices of males who completed the Men's Health Questionnaire?

Factors Influencing Sexual Attitudes and Practices

What factors may have contributed to the sexual attitudes and practices of the males who completed the Men's Health Questionnaire?

Health Clinic Utilization Preferences

What services would the participants be interested in receiving at the Clackamas County Health Department?

DEFINITION OF TERMS

Bisexual: A person whose sexual attraction and experience is with people of both sexes.

Heterosexual: A person whose sole or primary sexual attraction and experiences is with people of the opposite sex.

Homosexual: A person whose sole or primary sexual attraction and experiences is with people of the same sex.

Intercourse: For the purpose of this study, male intercourse is being defined as the insertion of the penis into the vagina.

Puberty: The period of time at the beginning of adolescence, when the secondary sex characteristics begin to emerge from the childhood body.

Sexual activity: The act of having sex with another person.

Sexual experience: For the purpose of this thesis, the term sexual experience refers to any activity that is sexual in nature, that involves one other person, and that may or may not include orgasm.

Sexuality: The cultural, ethical, psychological, and biological dimensions of the expression of sex.

Spermache: The first ejaculation of sperm from the male.

Stereotype: A set of characteristics generalized to people from the same group.

Some of these groups can be based on one's sex, sexual orientation, race, age, and occupation.

Virgin: A person who has not engaged in sexual intercourse.

Young males: This term will be used to mean both adolescent and young adult males. The ages of adolescence is 10 to 18, and the ages of young adult is 19 to 30.

CHAPTER II

LITERATURE REVIEW

INTRODUCTION

Within the confines of this literature review, questions about male sexual development, experience, and public health clinic utilization will be explored. Specifically, the questions addressed are as follows: What are the relevant issues of sexual development for males? When does the male sexual experience typically begin, and how do males experience their sexuality? Do males use contraceptives or protect themselves from sexually transmitted diseases? How do males feel about contraceptive use? What is the relationship between sexual activity and STD rates for males? And, what are some educational strategies that can be applied to contraceptive and STD education?

SEXUAL DEVELOPMENT

Sexuality is an important part of every person. Sexuality refers to all of the aspects of life that relate specifically to being a sexual human being. These aspects include cultural, ethical, psychological, and biological dimensions of the expression of sex. These dimensions of sexuality have helped society develop an outline of appropriate behaviors, which are called sex roles. These roles dictate the socially accepted behaviors of each sex (Bruess and Greenberg, 1988).

In the United States, both sexes have been guided by a society which requires restrictions on morality, especially sexual morality. These limits or restrictions cause a great deal of misinformation about sexuality (Stackhouse, 1990). The limits of what is *socially acceptable* in terms of sexuality, according to Stackhouse (1990), has changed over time. Lagers (1985) says that:

Only some of all possible sexual stimuli are socially valued. Social control and conventional sex training are meant to ensure that the objects to which people learn to respond sexually and the methods of sexual gratification they learn to prefer are within socially acceptable limits (p.184).

In the past, sexuality and topics of sexuality have been avoided. When sex is talked about, it usually is in terms of abortion, homosexuality, and pornography (Bruess and Greenberg, 1988). Bruess and Greenberg (1988) believe that this leads to sexuality only being discussed in negative terms. Although a number of religious associations have progressive comprehensive agendas regarding sexuality, they are not as visible as their counterparts (Stackhouse, 1990). The negative and more vocal groups have been very successful in limiting comprehensive sexuality education programs, which Stackhouse (1990) says leads to a very confusing concept of sexuality in the U.S. This confusion is most pronounced during adolescence. Adolescence is defined as the period beginning with puberty and ending with adulthood. Adolescence is a time when a solid understanding of sexuality is very much needed for young people (Steinberg, 1985; Jourard and Landsman, 1980).

Adolescence in males lasts for approximately ten years, typically starting at age 11 and lasting until age 21. The onset of adolescence varies from person to person, beginning as early as age 9 or 10, and as late as age 13 (Steinberg, 1985). Puberty is the

period of time, occurring at the beginning of adolescence, when the secondary sex characteristics begin to emerge from the childhood body. Most male youth begin puberty between the ages of 11 and 15, and most are fully developed by age 18 (Steinberg, 1985).

There are biological changes that occur in males which involve rapid growth of the body. This growth causes changes in height and weight of each male depending on the genetic information that their body has to guide its development. Genetics account for the variety of physical body types and sizes that are seen in males. According to Steinberg (1985), one of the most important changes in the bodies of males, in their own view, is the development of secondary sex characteristics. The changes that occur signal the onset of puberty, and they include deepening of the voice; enlargement of the testis and penis; and growth of hair under the arms, on the chest, in the pubic area, as well as on the face (Steinberg, 1985).

One of the psychological problems with the development of the male body focuses on the development of the genitals. According to Wanderer and Randell (1982), males of all ages seem to place a great deal of importance on the size of the penis, and without admitting it, they compare themselves to other males. The larger the penis, the more mature and masculine males think they are. The fact is that penises come in a variety of shapes and sizes, especially in the flaccid or non-erect state (Wanderer and Randell, 1982). When an erection occurs most penises are about six to seven inches in length and two to three inches in circumference. There is, however, a wide range of sizes, from three inches to twelve inches in length when erect, and two to five inches in circumference (Wanderer and Randell, 1982).

The average age of spermarche (first ejaculation) is 12.3 years, at which time 54 percent of males experienced nocturnal emissions and 72 percent have masturbated to ejaculation (Gaddis and Brooks-Gunn, 1985). Almost all males have not discussed with anyone their feelings before or after spermarche. But when males were asked about their feelings following their first ejaculation, in a retrospective study conducted by Gaddis and Brooks-Gunn (1985), 55 percent of the males felt grown-up, 18 percent were scared, 9 percent embarrassed, 82 percent were curious, 55 percent were surprised, 36 percent were happy, 36 percent felt proud, and 73 percent were excited. These numbers suggest that more information needs to be presented at an earlier age in order to facilitate a degree of preparedness and understanding for young males. This information can help males establish realistic expectations of their bodily functions prior to the bombardment of information, and misinformation, they receive in adolescence. For example, as Steinberg (1985) points out, one of the realities for males is that most are unable to produce enough viable sperm for fertilization of an ovum until about age 16. But, with the fact that males develop at different rates, the chronological age may be as young as 12 or 13 when viable sperm is present in the ejaculate or semen. This may be a real problem if the young male is already experimenting sexually with females (Steinberg, 1985).

Sexual development in males starts psychologically at a very young age. From the day males are born, they are treated differently than females. Adults stop touching males at an earlier age, which McCaffee (1989) says creates an unmet need in males to be touched. At the same time, while they are growing up, males are given the message that the only appropriate touch for males is sexual touch. They are told they should be

strong, independent leaders and that, in order for them to be masculine, they need to think of women as subordinates (Thompson, 1985).

Pleck (1974) defines the traditional masculine sex role as one where men are supposed to seek achievement and suppress emotion. He says, "we learn to mute our joy, repress our tenderness, control our anger, hide our fear. The eventual result of our not expressing emotion is not to experience it" (p. 4). Edwards (1987) says that "boys are conditioned at a very early age to believe that being masculine involves performance, dominance, competition, and achievement" (p. 1). Men are supposed to have no doubts, questions, or confusion about sex, which Zilbergeld (1978) says leads them to just fake it. Zilbergeld (1978) goes on to say that men cannot fake erections but they can fake orgasm and, more importantly, they can fake their feelings.

This inability to express feelings with respect to sex causes what Snell and Papini (1989) call sexual depression. The cause of this depression in males is related to their sexual preoccupation. That is, because males are not able to express their feelings about their sexual depression, they become sexually preoccupied in order to obtain a "sense of closeness and intimacy" (Snell and Papini, 1989, p. 232). This seems to be borne out by the fact that men report higher levels of sexual preoccupation than women (Snell and Papini, 1989).

The traditional views of masculinity cause men to isolate sex from other areas of life. Men tend to focus the meaning of sexuality in the genital experience, and the genitals then become an important part of the male self-image (Nelson, 1985). In a study on frequency of sexual urges, fantasies, and masturbatory fantasies in males by Jones and Barlow (1990), it was reported that 100 percent of men surveyed think about

sex at least once a day. They also found that 71 percent of the men reported becoming aroused thinking about a particular person, sex in general, and the sight and touch of their own bodies. This supports the conclusions drawn by Nelson (1985) that the sexual experience for males seems to be focused on the physical act of sex, an act which involves excitement, erection, sometimes penetration, and orgasm.

One of the greatest fears boys face while growing up, according to Friedman (1989), is homophobia. He says that it is more than a fear or hatred of homosexuals, but a fear of being perceived as gay. This fear compounds the problem of emotional maturity for males. Thompson (1985) says, "it is considered manly to take extreme physical risks and voluntarily engage in combative, hostile activities" (p. 5). Taking such physical risks helps males prove to others that they are not feminine, and hence, not homosexual. Male risk-taking has been played out in the media where the perpetuation of the masculine stereotype is predominate. Most male role models have been sexually exploitive and manipulative (Fabes and Strouse, 1984).

SEXUAL EXPERIENCE

In 1987, there were 23 million young men in the United States between the ages of 10 and 21 (Edwards, 1987). Of those, 62 percent, or 14.2 million, were sexually active, having had sexual contact with another person (Edwards, 1987).

The entrance into sexual activity for most adolescent males begins not with contact with another person but with masturbation. Thirteen years old is the median age for males to begin masturbation, and by age 15, 80 percent of males have masturbated (Atwood and Gagnon, 1987). Sarrel (1989) says of males that,

"masturbation is the chief way they learn about their sexuality; their bodily responses; their fantasies; the intensity of their drives; and about guilt, conflict, and efforts at self-control" (p. 4). The guilt and conflict related to engaging in this behavior produces anxiety, which is most often the result of a lack of accurate information about the basics of human reproduction and sexual response (Finkel and Finkel, 1983). The fact that young males masturbate (Atwood and Gagnon, 1987) as well as think about sex (Leigh, 1989) lends support to the contentions of Jones and Barlow (1990) that sexual thoughts are indeed related to sexual activity. The frequency of masturbation varies. Of those who masturbate, 5.2 percent participate daily, 26.4 percent masturbate two times a week, and 27.6 percent once a week (Atwood and Gagnon, 1987).

As young males become teenagers, they seek out partners for companionship which may eventually lead to sexual activity. Bigler (1989) found that 85 percent of American teens studied between the ages of 13 and 18 have had a boyfriend or a girlfriend. The progression from masturbation to having sex with another person is not necessarily a linear one. Engaging in sexual activity with another person usually starts with mutual masturbation, and/or petting, both of which involve the manual stimulation of the genitals by the individuals or by the partner. The initiation into sexual activity may be the result of either hormonal changes that influence behavior through arousal, or by the visible physical changes in the body. These physical changes, which become increasingly more evident to others, cause adjustments in social status and/or availability. The changes in physical appearance signal to others that they are becoming an adult (Brooks-Gunn and Furstenberg, 1989). Smith and Udry (1985) assert that this period of non-coital behavior helps provide time for males to adjust mentally and physically.

Sexual activity, or the act of having sex with another person, begins at different ages. Sonenstein, Pleck, and Ku (1989) found that 1.6 percent of the males studied had sexual intercourse by the age of 11. By age 15, 32.6 percent had engaged in sexual intercourse, by the age of 16, 49.9 percent had had sexual intercourse, by age 18, 71.6 percent had had sexual intercourse, and by the age of 19, fully 85.7 percent had had sexual intercourse. Similar studies of young males have found comparable results (Marsiglio and Mott, 1986; Hofferth, 1987; Elliott, 1989). Zelnik and Shah (1983) found that by the age of 18, 80 percent of their sample of males had had sexual intercourse.

The start of sexual activity for males is usually a *spur-of-the-moment* occurrence, with 75 percent of males not planning sexual activity in advance (Zelnik and Shah, 1983). Brooks-Gunn and Furstenberg (1989) say that "most teens do not consciously plan to become sexually active and they often do not foresee their first sexual experience" (p. 251). That is not to say that boys do not think about sex, they do. It just says that they do not plan or plan effectively for their first sexual experience. Faulkenberry, Vincent, James, and Johnson (1987) found that when comparing a sample of males who either started sexual activity at an early age (16 and younger) or at a later age (17 and older), those males who had intercourse at the early ages were more likely to have had those experiences with a casual acquaintance. The results showed that 51 percent of the sample's partners were casual acquaintances, and 38 percent were steady girl/boyfriend. For those who started sexual activity at the later ages, a smaller percentage (40%) were casual acquaintances, and more (47%) were steady girl/boyfriends, which may say, as you grow up you develop a need for pleasure first, then emotional closeness.

The three most important reasons males have sex according to Leigh (1989) are, first, pleasure, followed by emotional closeness, and then to please their partner. The three current reasons why males do not have sex are, first, fear of venereal disease or AIDS, then lack of opportunity, followed by either fear of pregnancy or lack of interest. Similarly, Faulkenberry et al. (1987) found that the number one reason males engage in sexual intercourse is to experience pleasure. They found that those who initiated sex under the age of 16 are less likely than those initiating sex over the age of 17 to want to experience emotional closeness and more likely wanting to experience pleasure. Juhasz and Sonnenshein-Schneider (1987) found corresponding results, in that males are much more influenced by the need for sexual gratification, most often in the form of sexual intercourse. This suggests that the younger males are looking for physical pleasure first, but as they grow older they are more likely to want to experience emotional closeness. This seems to be influenced by the rising consciousness of males in terms of what is expected of them according to the sex roles that are held by society in general. Males are not supposed to express their emotions. Instead they respond by seeking physical pleasure.

A form of sexual activity not previously discussed is that of oral genital contact. In a fairly recent study (Newcomer and Undry, 1985a), it was shown that 82 percent of teenage males who had had sexual intercourse had experienced oral genital contact. Of those, 69 percent had experienced both cunnilingus and fellatio. It was also found that for those males who had not had sexual intercourse, 24 percent had experienced oral genital contact. Of those, 12 percent had experienced both cunnilingus and fellatio. It was interesting to note that those males who had not had sexual intercourse were still

referred to as virgins even though they had participated in oral sex. Bigler (1989) also found that 25 percent of virgin males had either given or received oral sex. Although oral sex does not put males at risk of getting a female pregnant, it does place them at risk for STDs.

An often asked question of young males is whether or not having sexual activity with another male makes one a homosexual. The answer cannot be just a *yes* or *no* response. There are men whose sexual orientation is exclusively heterosexual; that is, they are attracted mainly to members of the opposite sex. Likewise there are males whose sexual orientation is exclusively homosexual; that is, they are attracted to members of the same sex. And then there is a segment of the male population for whom there is an attraction to both men and women, which is called bisexual. According to some of the most recent research done by the Kinsey Institute, 8 to 10 percent of males are homosexual, 20 percent are bisexual, and the rest are heterosexual. Although this places males into categories, the reality is that most males experience homosexual, heterosexual, and bisexuality in varying degrees (Remafedi, 1987). Among adolescent boys it is common for them to experiment sexually with other boys. Kinsey estimates that 38 percent of males have had same sex experiences by the age of 20 (Remafedi, 1987).

Given that there are 23 million males between the ages of 10 to 21 in the United States, assuming Edwards' (1987) figures are correct, then 2.3 million are homosexual, 4.6 million are bisexual, and the rest, 16.1 million, are heterosexual. Of that population of males, 8.7 million have had sexual experience with another male. Overall, 62 percent of this population has been sexually active. Similarly, a percentage of these males who

have had sex with another male are heterosexual by orientation. Although the percentage of heterosexuals is not known, it suggests that sexual experimentation for heterosexual males is not limited to just female partners.

An important psychological consideration with respect to adolescent sexuality is that of maturity. The immature adolescent may desire sexual intercourse and be aware of the reasons why they should not have sex, but they are generally incapable of making the needed decision to avoid it. This inability to make the decision to avoid sex is often the result of denial; that is, the inability to make the needed decision is a result of denying that the decision needs to be made (Juhasz and Sonnenshein-Schneider, 1987). Juhasz and Sonnenshein-Schneider (1987) strongly suggest that sexuality education programs must include efforts to increase *consequence-oriented* decision-making skills.

It has been shown that males participate in sexual activities at an early age, and that a significant number of adolescent and young adult males participate in sexual activities with multiple partners. It was reported in *Morbidity and Mortality Weekly Report* ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988) that 21 percent of the males age 18 to 29 who were surveyed in the General Social Survey had not experienced sex with a partner in the last 12 months. In this sample, 59.6 percent of those surveyed had one partner in the same period of time, 10.6 percent had two to four partners, and 2.2 percent had five or more partners. It was also found that 4.6 percent of the total sample had had ten or more sex partners in the same period of time. Baffi, Schroeder, Redican, and McCluskey (1989) found that in a survey of college-age students, 67 percent had had one partner in the last two months. Of that sample, 14 percent had had two sex partners in the last

two months, 5 percent had had three sex partners, and 3.33 percent had had four or more sex partners in the last two months. In another survey conducted by the Centers for Disease Control (CDC) ("HIV-Related Beliefs, Knowledge, and Behaviors Among High School Students," 1988), male students age 13 to 18 reported that between 24.2 and 67.3 percent of the sample had had sex with three or more sex partners depending on where they lived in the United States. This brief review demonstrates that males are indeed having sex with multiple partners.

Given the facts about male sexual activity, a number of questions arise. One of these questions is related to where sexual information is obtained. Reading was the most often cited source of sex information (Andre, Frevert, and Schushmann, 1989). The reading materials most often were obtained from peers (Atwood and Gagnon, 1987). In fact 75 percent of males learned about masturbation in this way. Another question frequently asked is whether or not sex education changes the male sexual experience. The decision to engage in sex was not found to be associated with having had sex education (Zelnik and Shah, 1982), although Danielson, McNally, Swanson, Plunkett, and Klausmeier (1990) found that sex education had a restraining rather than encouraging effect on male sexual activity. This suggests that sex education can help postpone the decision to have sex, and when the decision is made, it is an informed decision.

A major problem that faces efforts in sex education is sexually suggestive media. It is not that the media portrays sexual activity, but that the portrayals of sex do not include accurate sex information. Strouse and Buerkell-Rothfuss (1987) found that sexually suggestive media portrayals with inaccurate sex information negates all or most

accurate sex information learned in sex education classes. The two end up canceling out the effects of each other. This leaves young males, and females for that matter, without enough skills or knowledge to prevent pregnancy or STDs.

This is an area where parents can take an active role. They can help determine what should be watched, and explain where the information is eliminated or is inaccurate. Unfortunately this does not happen. Communication regarding sex generally does not occur between parents and children (Swan, 1980). Swan (1980) found that communication about sex does not happen because most parents do not have any information beyond basic anatomy and physiology. When there are sex-related conversations, parents and teenagers often disagree about what the conversation was all about. For most adolescent males, what is said by a parent is usually not heard, and if heard, it is rarely retained (Newcommer and Udry, 1985b). Baldwin and Baranoski (1990) assert that open communication between parents and adolescents is best established prior to adolescence. When open communication exists, a significantly greater amount of sex education is found to occur in the home (Baldwin and Baranoski, 1990).

CONTRACEPTIVE USE

The methods of contraception available for males are very limited. Condoms and vasectomies are the two primary methods for males to prevent conception. Adolescent and young adult males are not likely or typical candidates for vasectomies. This leaves the use of condoms as the remaining method of male contraception. Kirby (1989) found that only about 53 percent of all males used a condom at last intercourse

when no other birth control was used. In a larger sample of males, with the average age of 16.2, Melchert and Burnett (1990) found that only 24 percent had used condoms during last intercourse. Of that sample, only 22.6 percent of the males always used contraception, while 37.4 percent never used birth control. The number of males who always used contraception may be misleading due to the fact that 19.1 percent of the study sample thought that withdrawal was an effective method of birth control. In a study conducted by Fisher (1990), it was found that the use of condoms decreases as the number of partners increases. This may indicate that another form of birth control is being used by the sex partners. With an increasing number of partners and decreased use of condoms, pregnancy becomes more likely. This may also increase the likelihood of STDs being transmitted.

The lack of use of effective contraceptive methods by teenagers is evident in the 1988 pregnancy figures of females 15 to 19 years old. In Oregon, Henshaw and Van Vort (1989) reported that in 1988 there were 9,400 pregnancies in 15 to 19 year old females. Of those, half ended in birth and the other half in abortion. In Clackamas County, there were a total of 594 pregnancies in 1988 in women 19 years old and younger. Of those, 299 were aborted and 295 were live births (Murphy, 1989). The male partners of these teenage females are generally 15 to 24 years old and usually two years older than their partners (Henshaw and Van Vort, 1989). Teenage fathers are most likely to be high school dropouts, usually dropping out in their junior or senior years before they become fathers (Marsiglio, 1987). This is not surprising since the time spent on sexuality education, which averages 6 to 10 hours annually in the junior and

senior years of high school, would most likely have been missed by the dropouts (Barth, Middleton, and Wagman, 1990).

There is ample evidence that supports the delivery of explicit contraceptive education. Zelnik and Shah (1982) found that sex education is not associated with an increase of sexual activity. Danielson et al. (1990) assert that open, honest sexuality and contraceptive education, in fact, promotes sexual restraint. Likewise, sexuality education has been found to be associated with an increased likelihood of effective contraceptive use (Marsiglio and Mott 1986; Zelnik and Shah, 1982; Danielson et al., 1990; Gruber and Chambers, 1987).

The first few months after the beginning of sexual activity are the most critical in determining if a pregnancy will occur or not (Marsiglio and Mott, 1986). Adolescent males who have had sexuality and contraceptive education are more likely to be users of effective contraceptive methods (Lowe and Radius, 1987). Further, schools which also provide comprehensive health and social services, including reproductive health services, experience dramatic decreases in fertility and dropout rates, as well as better attendance records (Dryfoos, 1985b). Very few parents discuss sexuality with their children (Swan, 1980) and, even if they do speak to their children, they contribute very little, if anything, to effective contraceptive use. Furstenberg, Herceg-Brown, Shea, and Webb (1984) suggest that comprehensive sexuality education in the school setting appears to be very important in decreasing teenage pregnancies.

SEXUALLY TRANSMITTED DISEASE PREVENTION PRACTICES

Sexually Transmitted Diseases are just that, diseases that are primarily transmitted through sexual activity. Behaviors that eliminate or reduce the risk of being infected with one of the STDs will likely reduce the risk for all STDs. Avoiding exposure is the best strategy for preventing an infection with an STD ("Condoms for Prevention of Sexually Transmitted Diseases," 1988).

Currently the CDC estimates that there are about 2.5 million teenagers infected with an STD each year ("Premarital Exual Experience Among Adolescent Women," 1988). The current U.S. population is 260 million people. Eight percent, or roughly 18 million, are between the ages of 15 and 19. This means that 13 percent of the teenage population is infected annually with one of the major STDs each year in the U.S. The problem of STD's for men is one that needs immediate and direct attention. There are about fifty different types and strains of STDs which include Syphilis, Gonorrhea, Hepatitis, Chlamydia, HIV, Venereal Warts, and Herpes (Coates, 1990). According to the latest figures, 75 percent of all STDs reported each year are among young people ranging in age from 15 to 24 (Manning et al., 1989). Of those, about 60 percent are males. The higher percentages of STDs in males is most likely due to the relatively easier detection of STDs in men. Another factor may be that men have more sex partners on average than do women ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988). While teenagers have high numbers of STDs, young adults are also experiencing high incidence rates. Men ages 20 to 24 years have the highest incidence of Gonorrhea among males. This is followed

by the 25 to 29 age group, then the 15 to 19 age group, with the highest incidence of Gonorrhea among males (Coates, 1990).

During the last decade, the HIV, or Human Immunodeficiency Virus, has been the STD of greatest concern. This concern is due to the fact that death is often a result of infection. According to the then Surgeon General Koop (1986), transmission occurs three ways. These routes of transmission include sexual contact, exposure to infected blood, and passage of the virus from a mother to her infant. The body fluids that are known to be infectious include blood, semen, and vaginal secretions, which may account for female to male transmission. Other possible but not very likely candidates for virus transmission include breast milk, saliva, tears, urine, cerebrospinal fluid, and feces. And, research has shown that AIDS is not likely to be contracted through casual contact (Kelly, 1989).

In terms of infection with HIV, the type of sexual activity that is engaged in is very relevant. It has been shown that anal intercourse is a very effective sexual practice for the transmission of HIV. This is mostly due to the microscopic tears in the epithelial tissue of the anus and rectum which creates a direct route into the bloodstream (Quinn et al., 1988). Unprotected anal intercourse is one of the major original routes of transmission in the homosexual population infected with the virus. Likewise, HIV infections in heterosexuals has been found to be associated with anal intercourse. Approximately 30 percent of the heterosexual sexually active population has participated in anal sex at one time in their sexual history, and many of those participate frequently. Women were found to be 2.3 times more likely to become infected with HIV if they had participated in anal sex (Padian et al., 1987). A past

history of STDs increases the likelihood of being HIV infected. This is due to the fact that a majority of STDs disrupt the epithelial surface, and consequently provides a prime route of HIV transmission (Quinn et al., 1988).

The CDC currently estimates that there are 1 to 1.5 million people infected with HIV, which translates to approximately 150,000 people who may be infected between the ages of 15 to 19. This represents 2 percent of the sexually active population in this age group in the U.S. The doubling time for this infection (the time for the number of people infected to double) is 13 months. At this rate, in 13 months 4 percent of the sexually active population will be infected and in 26 months, 8 percent, and so on ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988). In Oregon, using these statistics represents extrapolated numbers of between 15,000 to 20,000 infected people of all ages. Of those, 1,200 to 1,600 persons are infected between the ages of 15 and 19. These people may or may not know that they are infected at this time, but most likely they will become AIDS patients and die within 8 to 10 years.

It was shown in the previous section on sexual experience that multiple sexual partners is a part of many adolescent and young adult males' sexual experience. Reiss and Leik (1989) believe that a realistic number of lifetime sexual partners for the average male is 5 to 10. Reiss and Leik (1989) showed that once a person has sex with five people, their safety margin for HIV infection is essentially eliminated. Therefore, having sex with five people makes the probability of being infected with HIV very high, especially if sex is unprotected anal or vaginal sex. Reiss and Leik (1989) suggest that efforts to limit the number of partners is a "potentially futile strategy." Recent studies

have shown that 4.6 percent of never-married heterosexual men ages 18 to 29 years old reported more than 10 sex partners in the past twelve months ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988). This means that over 700,000 single heterosexual men ages 18 to 29 in the U.S. may have had 10 or more sex partners in the last year (Condoms for Prevention of Sexually Transmitted Diseases," 1988). These young men have already reached their safety margin just in the last year (Reiss and Leik, 1989).

Currently in the U.S., the male/female HIV infection ratio is 13:1. In the adolescent population in the U.S., it is 7:1. In New York City in the adolescents aged 13 to 21, the ratio is 2.9:1. The ratio in the African population is very nearly 1:1 (Hein, 1989).

Males are having sex as early as age 13, with 7.5 to 47.7 percent of them having sex with multiple partners, and up to 38 percent of them having same sex partners. Given the fact that only 8 percent of males report always using condoms (Kegeles, Adler, and Irwin, 1988), it can be concluded that young men are at risk for many STDs, including HIV. Another indicator of risk is to look at the present demographics of AIDS patients. Nearly 21 percent of all persons diagnosed with AIDS are between the ages of 20 and 29. Given that the mean incubation period of HIV infection to AIDS diagnosis is 10 years, those 20 to 29 years old would have been infected between the ages of 10 and 19 (Greespan and Castro, 1990). Males between the ages of 20 and 29 are in the group that is increasing at the fastest rate for heterosexual transmission ("Number of Sex Partners and Potential Risk of Sexual Exposure to Human Immunodeficiency Virus," 1988; Hein, 1989).

Although condom use among sexually active males ages 17 to 19 has increased from 21.1 percent in 1979 to 57.5 percent in 1988, most (78.8 percent) still believe condoms are too much trouble. When asked if they intended to use condoms during sexual activity in the next month, 50 percent of the males surveyed said no (Sonenstein, Pleck, and Ku, 1989). Males also possess a high degree of knowledge about transmission of AIDS, but when asked if they had changed their own behaviors in response to AIDS, 55.8 percent said no (Katzman, Mulholland, and Sutherland, 1988). Besides being too much trouble, several other reasons for not using condoms have been expressed by males. Among them are the following: too small or tight; decrease in sensitivity; spoils love making; and embarrassed to buy them or use them (Kelly, 1990). The reality is that these reasons are likely to be the result of ignorance. Most males have not had instruction on proper use of condoms, and most are not aware of the variety of condoms that are available (Hatcher and Hughes, 1988). We already know that male penises are not all the same size, but neither are condoms. There is a variation in size of standard condoms, some being tighter or shorter than others. Recently on the market are a couple of new condom choices. These are made longer and larger to accommodate the well endowed male (Hatcher and Hughes, 1988). Condom failure is usually a result of not using it correctly (i.e., not unrolling the condom completely or not leaving room at the tip) and often results in condom breakage. The use of oil-based lubricants will also result in failure by destroying the latex of the condom ("Condoms for Prevention of Sexually Transmitted Diseases," 1988). The breakage rate for condoms during vaginal intercourse is 1:129. That is for every 129 acts of intercourse using a condom, one breaks. The rate for anal intercourse is

half that (Hatcher and Hughes, 1988) In the case of STD transmission, including HIV, the use of spermicides increases the effectiveness and protection provided by condoms, but spermicides should not be used alone ("Condoms for Prevention of Sexually Transmitted Diseases," 1988).

PUBLIC HEALTH CLINIC UTILIZATION

It is safe to say that most services that are offered by public health clinics in general, and Clackamas County specifically, are directed toward women and their children. In 1989, 2,917 patients were seen in family planning at the Clackamas County Health Clinic. Of those, approximately 1,800 were women 19 and younger. Only 10 of the patients were males. During the same year, 370 patients were seen in the STD clinic. Of those, 60 percent were male (Murphy, 1989). This low usage may be due to the fact that a large portion of males think that family planning is for women, and having an STD is the only reason to go to the health clinic.

The money that is available for family planning on a federal level comes from the Title Ten budget. This budget designates 95 percent of its funds to family planning, with nonspecific consideration given to services for men (Danielson et al., 1990). The majority of the personnel at the Clackamas County Clinic are female, which may make it difficult for men to seek services in the clinic. This is supported by a recent study in which 88 percent of the males with a health problem reported they prefer to be seen by male health professionals (Neinstein, Shapiro, Rabinovitz, Beer, Church, and Sasso, 1989).

One of the problems with obtaining an accurate picture of public health clinic utilization by males may be due to the fact that records of male utilization are not required. Another reason is because there are very few, if any, programs offered at the clinic that directly target male populations (Danielson et al., 1990).

EDUCATIONAL STRATEGIES

Males develop at differing rates and the need for information about the process of development must be available if we expect them to become healthy, fully functioning adults. Scales (1987) believes that knowledge leads to responsible actions and that ignorance produces irresponsibility with respect to sexuality.

Brick (1989) outlined some of the most important characteristics of adolescent sexual health, the knowledge of which is important to this development. The four areas of knowledge includes body image awareness, interpersonal relationships, decision-making, and sexual intimacy. An expanded list of the characteristics in each area can be found in Appendix A.

While biological factors shape some of male behavior, Thompson (1985) says that "there is undeniable evidence that cultural and environmental factors can override biological impulses" (p. 6). This supports what Brick (1989) outlined as needed education for healthy sexual development. It is the lack of this knowledge that often leads to pregnancies and STDs.

The need to get males involved in pregnancy prevention as well as STD prevention is quite clear. Teenage females do not get pregnant if teenage males take precautions to ensure that semen does not enter the female body. Likewise, teenage

males do not become infected with an STD if they take precautions to prevent coming into contact with their partner's body fluids.

Despite intensive research efforts, prevention is the only effective control strategy at present. Because STDs are transmitted almost exclusively as a result of behavior individuals can modify, educational programs designed to influence relevant behavior can be effective in controlling the epidemic. Similarly, pregnancy prevention can be accomplished using the same strategies to prevent STD transmission. It is highly unlikely that an effective behavior modification strategy can be applied to the entire population of males, especially where sexual experimentation is concerned. It is far more likely that prevention of STDs can be accomplished by encouraging safer sex practices for individuals. Likewise, decreasing the number of teenage pregnancies can be accomplished by encouraging practices that eliminate the possibility of conception. This approach allows a person to still have sex, but in a safe, protected, and responsible manor.

Education about sexuality may be more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and conception, which are often related. It may also have greater impact when they have more opportunities to develop such qualities as decision-making and communication skills, resistance to persuasion, and developing a sense of self-efficacy and self-esteem (Windsor, Baranowski, Clark, and Cutter, 1984). Males in this population need to learn refusal skills by going through role playing exercises. They need to learn to make informed choices about sex, and when making the choice to have sex, they need to learn about prevention of both STD and pregnancy. They also need to learn how to assess

their risk of each. Sexuality knowledge may be more effectively taught if motivation-building, attitude-changing exercises are included in sex education programs (Eisen and Zellman, 1986).

Merely introducing STD and pregnancy prevention information to students is not a guarantee student attitudes, beliefs, and consequential behaviors will change. The key problem, failure to avail oneself to condoms, is often the result of faulty, immature perceptions about risk and overestimation of the cost of condoms, both in time and money. The introduction of condom-use and its effect on STD prevention and pregnancy prevention must be coupled with explicit information on how the two events are linked to not taking precautions, like using a condom. This includes information on how condoms work to prevent STD and pregnancy, how to use condoms, and information on how and where to obtain condoms. Efforts to make an STD or pregnancy occurrence seem a more likely and serious outcome of unprotected intercourse can help young males realize the importance of condom use.

One of the strategies often talked about in terms of preventing STD and pregnancy is abstinence. This strategy says that not having sexual intercourse is the only 100 percent effective method of contraception or STD prevention. At face value, this may be true, but as Gochros (1988) points out, this approach can give a false sense of security. In terms of STD, unless each person entering a mutually monogamous relationship has never had a previous sexual experience, then they both would need to be tested to make sure STDs are not present in one or both of their bodies. Even if negative tests are obtained in the case of HIV infection, negative tests can be obtained for up to a year after infection. What this means is that only virgins can be sure about

the risk of STD infection. But as Newcomer and Undry (1985a) found, 24 percent of males who have experienced oral genital contact are also identified as virgins because they have not had traditional penis vaginal intercourse. Oral sex has been a hot topic in terms of whether or not HIV can be transmitted this way. Since it is known that HIV can be transmitted through a break in the epithelial tissue of the body, then it follows that breaks or tears in the epithelial tissue in and around the mouth can be avenues of transmission. These breaks or tears can be the result of trauma, flossing the gums around the teeth, cold sores, chapping of the skin, and sores caused by other STDs.

The strategy of abstinence applied to pregnancy prevention can be a most effective prevention strategy. But as Gochros (1988) points out, many young males believe that if they do not *go-all-the-way*, or do not actually insert the penis into the vagina, then they are abstaining from sexual intercourse. The fact is, since sperm swim, if the male ejaculates on or near the vagina, the possibility of pregnancy is very real.

Fisher (1990) outlines what is called "The Preventive Behavior Sequence" (see Appendix B). This approach includes abstinence with the realization that we are all sexual beings. This comprehensive approach is applicable to both STD and pregnancy prevention.

What has been discussed up to this point is the development of educational objectives that can be used to create a healthy environment of knowledge, skills, and choices for adolescent and young adult males in terms of sexuality development. What needs to be discussed now is what to do for those young males who have already decided to have sex.

A recent risk reduction model was developed by Catania, Kegeles, and Coates (1990), called the AIDS Risk Reduction Model (ARRM) (Appendix C). While this model was developed for use as an STD prevention model, it is applicable for use as a pregnancy prevention model as well. This is due to the fact that some of the sexual behaviors involved in STD transmission are the same sexual behaviors that are involved in conception. According to the authors of the model, the framework for ARRM is taken from other models that have dealt with social psychological problem-solving. It integrates elements of the Health Belief model and self-efficacy theories. The premise of this model is that in order to avoid HIV infection, people participating in high risk behaviors need to understand that their sexual behaviors place them at risk of infection. They then need to make a commitment to change their behavior. And, finally, they need to enact the changes that will prevent transmission of HIV. The three stages of this model then are: labeling, commitment, and enactment.

The first stage of labeling is problem perception which requires the individual to first have knowledge of the connection between sexual activities and HIV transmission. They need to believe that they are personally vulnerable, or perceive that they are susceptible to HIV infection. Further, the individual needs to be in tune with their social network, which often influences what direction people take in terms of behaviors.

The second stage involves the commitment to change. This is where decision-making is important. With an increased knowledge base that is getting through stage one, a person has the information about why a change is needed. In terms of sexual behavior, it is a very difficult process to go through. Changing one's sexual behavior

may mean that a person has to add or drop a variety of sexual and sex-related behaviors that they believe are pleasurable or not, whichever the case may be. The commitment to change requires a person to explore the perceived costs and benefits of changing high risk behaviors. It also requires a person to examine their own beliefs concerning their ability to make the appropriate changes. In this stage three questions are asked: (a) will my enjoyment of sex be affected by changes I might make?; (b) will the changes be successful in reducing my risk of HIV infection?; and (c) can I perform or learn to perform the actions that will lead to changes and obtain the outcome I want?

Stage three, is the enacting stage where a person takes the appropriate actions to make the changes that they committed to in the first two stages. This stage is divided into three phases. The first phase is information seeking. This is where individuals begin to gather ideas about ways to change high risk sexual behaviors. The second phase is where individuals seek help. This can be self-help, informal help from friends, or formal help from a health care provider. Factors that influence help-seeking include self-esteem, social network, success or failure of prior attempts, perceived importance of the problem relative to other ongoing problems, and resources that are required. The third phase involves enacting the solutions. The most important part of this phase is sexual communication skills. The individual needs to be able to communicate well with sexual partners in order for them to get the safer sex message across. The sexual partner needs to have also gone through the three stages, because success in reducing high risk behaviors requires this social support.

Movement from one stage to the next, requires an individual to have achieved the goals of the prior stages. A number of factors affect one's ability to move from one

stage to another. The emotional state of mind is one factor that affects the achievement of goals. People who are distressed, or have fear or high anxiety about condom use or other prevention activities, may not use the measures of protection. On the other hand, fear or anxiety about getting AIDS may be the push that is needed to get the individual to use protection. Another factor that affects one's ability to move through the stages is to forget about the need for protection.

The authors of the article concluded by saying the following:

[E]xternal cues may stimulate progress towards solving health problems. Public education campaigns that detail risk behaviors, condom use, and sources of help may provide people with cues for correctly defining problem behavior, for enhancing commitment to change, and for where to obtain and how to implement solutions (Cantania, Kegeles, and Coates, 1990, p. 66).

Males who choose to continue to be sexually active, have only one method of prevention available to them. This method is the use of a condom to prevent STD transmission and conception. Many males have irrational ideas and fears about the use of condoms and need to learn ways to change their cognitions about prevention and condom use.

The systematic, rational restructuring approach developed by Ellis (1962) can be used to modify behaviors that place men at risk for STDs and conception. By following its four steps, an appropriate cognitive change method can be developed for the change in behavior from having unprotected sex to using condoms as protection from both STD and pregnancy.

The first step in systematic rational restructuring applied to this problem involves looking at what men tell themselves about condoms and their use. St. Lawrence and

Kelly (1989) identified several attitudinal barriers to condom use, which included the following:

1. Condoms lower sensitivity during sex.
2. Condoms are unnatural.
3. Condoms are only for birth control.
4. Concerned that sexual partner will be offended.
5. Failure to anticipate that sexual activity may happen.
6. No need for protection because a cure for AIDS will be here soon.
7. Belief that condoms are for people that are promiscuous.
8. Embarrassment about purchasing condoms.
9. Makes sex seem artificial or premeditated.

The second step is to show men the irrationality of their beliefs about condoms. Ellis (1962) has compiled a list of irrational beliefs that can be used to get the individual to determine which of these beliefs are connected with their beliefs about condom use. The individual needs to have a clear understanding about which of the irrational beliefs they hold (Appendix D).

The next step is to get the individual to come up with alternative statements about the barriers they have to condom use. The following are examples:

1. Condoms are very sensitive if I put a little lubricant inside before I put it on.
2. Natural is being safe, so condom use is natural.
3. Condoms are used for both birth control and disease protection.

4. I am being honest when I request that condoms be used during sex. After all, you can't always tell if someone has an STD.
5. I will always carry condoms with me so that I will never be without.
6. AIDS has been around for more than ten years, and it is highly unlikely that there will be a cure in the next ten years.
7. What's promiscuous? It only takes once to be infected.
8. Why be embarrassed about being responsible, and besides I am being a role model by letting people see me buy condoms.
9. Condoms add spice to the act of having sex.

The fourth and last step in rational restructuring is to get the appropriate thoughts to come up when confronted with the opportunity for sex. This may take rehearsal of self-statements before they are needed.

Condoms should be used every time oral, vaginal, or anal sex is participated in. One of the problems males have is that most have never been taught how to properly use a condom. User instructions can be found in Appendix E.

While condoms provide a good measure of protection when used properly, there are many other sexual activities that may have the potential for STD infection. Appendix F categorizes sexual activities in terms of their possible level of risk for STD transmission. Those activities that do not have the potential to exchange bodily fluids are termed safe sexual practices. Those sexual activities that may have the possibility of STD transmission are termed possibly safe. Those sexual activities that are known to be routes of STD transmission are labeled unsafe sexual practices.

SUMMARY

The questions are answered based on findings of the literature review. Each of the questions are posed and answered as follows:

What are the relevant issues of sexual development for males?

Sexuality development for males involves many issues that are relevant to the topics of this thesis. The most important of these issues is the limited amount of accurate information that males receive with respect to their sexual development. Topics that are often eliminated or superficially covered in males sexuality education include body growth and changes in terms of what to expect and when, the variety of body types and sizes, the similarity and differences in terms of sexual orientation and expression, and aspects of masculinity and expressing a wide range of emotions, including stereotypical female emotions. Topics like masturbation, sexual experimentation, sexual orientation, contraceptive use, and oral sex are left out of sex education curriculums. Without accurate comprehensive information in these areas, males are left in the dark, leaving males unprotected for the situations in which they often find themselves.

When young males are not knowledgeable about the changes that their body will go through, they are unprepared for the changes that occur. They often seek information from their peers about these changes. The information that they receive from their peers is often incomplete and inaccurate. The lack of accurate information gives young males an unstable foundation or knowledge base, which in turn leaves them to the development of unrealistic expectations about how they should and should not act in a situation involving aspects of their sexuality.

Young males develop at different rates, both physically and mentally. Whereas a young male may have the body of a young adult, he may still have the mind of the 14 or 15 year old. Likewise, a 14 or 15 year old male may be as mature as a young adult mentally, but at the same time have the body of an early pubescent male just developing. The result of these differences are often more negative for the male that is not developing at the rate that many of the other males around him are developing. Providing information to all the males about the differences in their development may not stop all the ridicule, but it may help most understand why they are not all alike.

Sexual orientation means more than just what sex you are attracted to; it also means how you express your sexuality. Not all heterosexual males want to get married and have children. Neither are all interested in the same forms of sexual expression. Likewise, homosexual males are not all interested in expressing their sexuality in the same fashion. If we provide males with information about the variety of options that are available in terms of sexual expression, they can be more comfortable with who they are and how they decide to express their sexuality. The concept of individually consenting expression of sexuality should be adopted and taught. Providing accurate comprehensive information is important and should not be tied up with one group of people dictating what is acceptable in terms of the expression of individual sexuality.

When does the male sexual experience typically begin and how do males experience their sexuality?

Sexual experience for males begins at an average age of 13, and is first experienced through masturbation. Masturbation is the primary means by which young males learn about sexual feelings and response. Sexual activity with a partner usually

first involves mutual masturbation before intercourse becomes part of their sexual experience. By the age 15, a third of young males have experienced intercourse, by age 16 half have experienced intercourse, and by age 19, 85 percent have experienced sexual intercourse.

Sexual experience for 75 percent of young males is not a planned event. Although it is a highly anticipated event, it is not planned or planned effectively to prevent conception or STDs.

Recent studies indicate that 40 percent of young males' partners are casual acquaintances, and slightly more (47 percent) are boy/girlfriends (Fualkenberry et al., 1987) Young males participate in the same sexual activities as adults, including oral sex. Most (82 percent) males have experienced oral sex. Of those, 24 percent have not previously experienced intercourse, and in fact are often still considered virgins.

Sexual activity is expressed in a variety of ways; most of these are participated in by heterosexual, bisexual, and homosexuals alike. The activities are the same, only the gender of the partner is different. At any rate, the percentage of males in each of the aforementioned categories have remained fairly constant through the research, with 70 percent heterosexual, 20 percent bisexual, and 10 percent homosexual. It is not uncommon for young males to experiment sexually with the same sex even if their primary sexual orientation is heterosexual.

Sexual experience is very much a part of young males' lives. In fact this sexual activity for a quarter of young males is frequent and with multiple partners. In a study conducted by the CDC ("Condoms for Prevention of Sexually Transmitted Diseases," 1988), male students age 13 to 18 reported that between 24.2 percent and 67.3 percent

of the sample had had sex with three or more sex partners, depending on where they lived.

Do males use contraceptives or protect themselves from STDs.

Depending on which study you look at, between 25 and 50 percent of young males used condoms the last time they had had intercourse. Most young males who use condoms use them primarily for the purpose of contraception. When asked if they intended to use condoms the next time they had intercourse, 50 percent or more have said no. Since condoms are the only real contraceptive and STD prevention method for males in this age group, efforts to link the need for the use of condoms with the problems that are possible if they are not used is necessary. This is especially needed since so many males do not use condoms every time, or at all.

How do males feel about contraceptives?

The only realistic contraception for sexually active young males is the use condoms. As it happens, the condom is also the only STD prevention method available to sexually active young males. Most males believe that condoms are too much trouble, both in obtaining them and in using them during sexual activity. The most common reasons why males say they do not use condoms is that they are too small, they decrease sensitivity, they spoil love making, or they are too embarrassed to buy them. The males in this study expressed the same reservations about the use of condoms as most males in other studies.

What is the relationship between sexual activity and STD rates for males?

Sexually transmitted diseases are just that--diseases that are transmitted through sexual activity. Males begin sexual activity at an early age, and by age 18, 70 to 80

percent have had a sexual experience with another person. Study after study has shown that young males have had sex with multiple sexual partners. Teenage males have sex with casual acquaintances almost as often as they have sex with people that they know. And in both cases these males have active sex lives. The males in boy/girlfriend relationships are often in them for short periods of time, going from one relationship to the next. This combination of sexual activity with casual acquaintances and serial monogamous relationships, provides a perfect environment for STDs to be as rampant as they are in the young male populations in this country.

What are some educational strategies that can be applied to contraceptive and STD education?

Adolescent and young adult males are having sex, and despite efforts to control their sexual expression, many will start or continue to have sex. The consensus of sexuality educators recommends that comprehensive accurate sexuality education, that includes, among other things, decision-making and communication skills, be taught to young males prior to their actually needing this information.

Merely introducing STD and pregnancy prevention information to students is not a guarantee that their attitudes, beliefs, and consequential behaviors will change. They also need explicit information on how STDs and pregnancies are linked to not taking precautions, like using a condom. This information includes how condoms work to prevent STDs and pregnancy, how to use condoms, and information on how and where to obtain condoms.

Systematic rational restructuring can be used to facilitate changes in behavior by changing how males think about condoms and their use. Similarly, the AIDS Risk

Reduction Model can be used to understand personal risk in terms of STDs and pregnancy. The premise of the model is that in order to avoid STDs or pregnancy, people participating in behaviors that place them at risk need to understand those risks. They then need to make a commitment to change, and finally, they need to make the changes.

CHAPTER III

METHODS

QUESTIONNAIRE DEVELOPMENT

The questionnaire was developed in several stages. Mary Murphy and Dixie Whetsell of the Clackamas County Health Department used focus groups of males 15 to 40 years old to determine what services they would be interested in receiving and what topics they would be willing to talk about. The author used this information to develop a long list of questions. Suggestions in terms of appropriateness of each question was solicited from Dr. Judy Sobel and Dr. Dawn Graff-Haight from the Department of Health Studies at Portland State University. The final 48 questions were chosen and then written at a sixth grade comprehension level by the author.

The questions covered demographic information including age, employment status, student status, and religious preference. They also covered sexual orientation, sexual experience, contraceptive use, STD prevention practices, and public health clinic utilization. The complete Men's Health Questionnaire can be found in Appendix G.

DATA COLLECTION

The Clackamas County Health Department is a multi-service facility with an emphasis placed on family planning and STD treatment services. Other services that are available include stop smoking groups, blood pressure checks, cholesterol tests, and sports and job physicals.

The total number of clients served in 1989 was 3,287. Of those, 232 were males, 95.6 percent of whom were seen for STDs. The staff is made up of six clerical workers and five family planning and STD nurses.

The data collected were obtained with the use of the Men's Health Questionnaire, which was a 48-question, self-administered questionnaire. The first one hundred ($n = 100$) completed questionnaires were obtained from June 11 to October 26, 1990. Initially, available staff members attempted to ask all males who came into the clinic if they would fill out the Men's Health Questionnaire. The dissemination of the questionnaire was not top priority; therefore, it is very possible that this sample represents only a percentage of the total number of men, ages 15 to 40, who came into the clinic. In order to ascertain what percentage the first set of questionnaires represented, a second set of 25 questionnaires was obtained. Between the dates of December 3 and December 14, 1991, one staff member was stationed at the front counter of the clinic. Every male who entered the clinic was asked to fill out the questionnaire if they were between the ages of 15 and 40. In that ten day period, 29 males came into the clinic for their own appointments or with another person. Twenty-five of the 29 males completed the Men's Health Questionnaire, and 4 males declined to participate. Using these figures, during this two-week period, 86 percent of all the males who entered the clinic completed surveys.

An average of ± 2.0 percent was found on all yes and no questions when comparing the first set of one hundred questionnaires with the last 25 questionnaires. That is, the results between the two groups differed an average of ± 2.0 percent on all yes/no answers. For the purpose of the thesis, the two samples do not differ significantly. The samples were joined and no further separate analyses were conducted.

Subjects (n = 125)

The subjects consisted of males aged 15 to 40 who came to the Clackamas County Health Department for their own appointment or with another person and who agreed to complete the survey.

Procedures

Each male between the ages of 15 and 40 who entered the Clackamas County Health Department was asked to complete the Men's Health Questionnaire, which was a self-administered 48-question questionnaire. The participants filled out the questionnaire in the waiting room with the other clients. Completion of the questionnaire took approximately 10 minutes.

Human Subject Approval

Human subject approval was obtained pursuant to university requirements. The application for approval as well as the approval memorandum can be found in Appendix H.

CHAPTER IV

RESULTS

The data were analyzed with the use of SPSS-X 3.1 IBM software. The data file contained 125 cases and frequencies were obtained on all questions. Cross-tabulations were done on selected questions to see if any causal correlations could be made. Complete results are provided in Appendix I. The following is a summary of the important information obtained from the questionnaire.

DEMOGRAPHICS

The results of this questionnaire showed that the average age of the male participants was 20.8 years. The range of ages was 15 to 40, with 20.7 percent of the participants ages 15 to 18, 73.8 percent ages 19 to 30, and 1.6 percent 31 years old or older. This population of males was 94.4 percent white, 3.2 percent Hispanic, and 2.4 percent American Indian. Students made up 24 percent of the sample. Those employed made up 72.0 percent of the sample. Most of these (29.2 percent) were construction workers, 15.7 percent were involved in sales, and 11.2 percent in automotive repair. The majority (53.6 percent) of this sample of males had never been married; 17.6 percent were engaged, and 20.8 percent were married. A total of 25.8 percent of the males lived with their parents, 20.8 percent lived with a relative, 21.6 percent lived with a married/sexual partner, and 47.4 percent lived in another type of relationship setting. No religious preference was reported by 46.2 percent, 18.4 percent identified themselves as Catholic, 12.6 percent Protestant, and 22.6 percent chose

"other" form of religion. The vast majority (72.5 percent) said they never or rarely attended church, another 19.3 percent said they sometimes attended church, and 8.0 percent said they often or always attended church.

SEXUAL ATTITUDES AND BELIEFS

A few questions were asked to determine what frame of reference the participants had, in terms of what they think and believe about some aspects of sexuality. The first question asked in this area dealt with having talked with their parents about sex and whether or not they felt comfortable with the talk. A majority (59.6 percent) had talked with their parents about sex. Although the specifics of what was discussed was not determined, slightly more of the males (51.2 percent) were not comfortable with the conversation they had with their parents about sex (see Table I).

TABLE I
TALK WITH PARENTS ABOUT SEX

	Yes		No	
	Number	Percent	Number	Percent
Talk with Parents (n = 121)	74	59.6	50	40.3
Comfortable with Talk (n = 121)	59	48.7	62	51.2

Most (70.5 percent) of the males said that they have in the past examined their own genitals. Almost a third (29.4 percent) of the male participants said they have never examined their genitals.

Another question asked of the male participants was how they felt about sharing contraceptive responsibility. The majority (84.0 percent) of the males believe that they

should always share the responsibility for contraception with their partner (see Table II).

TABLE II

SHARE CONTRACEPTIVE RESPONSIBILITY WITH SEXUAL PARTNER

	Number	Percent
Never	3	2.4
Rarely	1	0.8
Sometimes	8	6.4
Often	8	6.4
Always	105	84.0

n = 125

When the participants were asked to identify which form of birth control was 100 percent effective, 76.8 percent said that "saying no" was 100 percent effective. All other choices combined totaled 21.6 percent (see Table III).

TABLE III

100 PERCENT EFFECTIVE METHOD OF BIRTH CONTROL

	Number	Percent
Saying no	96	76.8
Do not know	10	8.0
Condoms	9	7.2
Pill	8	6.4
IUD	2	1.6

n = 125

When asked about how they felt about condom use, the two most frequently given answers were first that condoms reduced pleasure (62.1 percent) and second that they felt protected (57.9 percent) when using them (see Table IV).

TABLE IV
HOW MALE PARTICIPANTS FEEL ABOUT CONDOMS

	Number	Percent
Reduce pleasure	74	62.1
Feel protected	69	57.9
Partner will not like	44	36.9
Other	15	12.6
Feel embarrassed	10	8.4
Like feel	7	5.8

n = 119

When asked what would make it more likely for them to use condoms, 25.3 percent said "fear of STDs." Equally, 10.6 percent of the males said they would be more likely to use condoms if "their partner requested," "if they got a new partner," and if condoms "did not reduce pleasure" (see Table V).

TABLE V
WHAT WOULD MAKE IT MORE LIKELY FOR
MALE PARTICIPANTS TO USE CONDOMS

	Number	Percent
Fear of STD	19	25.3
Other	17	22.6
Partner requested	8	10.6
Did not reduce pleasure	8	10.6
New partner	8	10.6
None	6	8.0
Many partners	5	6.6
Thinner	4	5.3

n = 75

SEXUAL EXPERIENCE AND PRACTICES

The male participants identified themselves as being mostly (87.8 percent) heterosexual, with 5.6 percent identifying themselves as bisexual and 2.4 percent as homosexual (see Table VI).

TABLE VI
SEXUAL ORIENTATION OF MALE PARTICIPANTS

	Number	Percent
Heterosexual	108	87.8
Bisexual	7	5.6
Homosexual	3	2.4

n = 123

The average age for first orgasm was 13.8 years old, with 53 percent of the participants experiencing their first orgasm between the ages of 12 and 15. The average age for first intercourse in this population of males was 14.8 years old, with 54.2 percent of the experiencing intercourse for the first time between the ages of 13 and 16 (see Table VII).

TABLE VII
AGE OF FIRST ORGASM AND FIRST SEXUAL EXPERIENCE

First Orgasm			First Intercourse		
Age	Number	Percent	Age	Number	Percent
U8	5	4.5	U8	6	5.3
9	3	2.7	9	1	0.8
10	1	0.8	10	0	0.0
11	4	3.6	11	1	0.8
12	14	12.8	12	7	6.2
13	24	22.0	13	15	13.3
14	16	14.6	14	20	17.8
15	15	13.7	15	16	14.2
16	12	11.0	16	19	16.9
17	7	6.4	17	10	8.9
18	3	2.7	18	6	5.3
18+	5	4.5	19	7	6.2
			20	2	1.7
			21	1	0.8
			22+	1	0.8

n = 121

Most (97.4 percent) of the males had experienced sex with a female, 1.7 percent experienced sex with a male, and only one male said he had experienced sex with both genders (see Table VIII).

TABLE VIII
SEXUAL EXPERIENCE WITH FEMALE, MALE, BOTH

	Number	Percent
Female	114	97.4
Male	2	1.7
Both	1	0.8

n = 117

Of the participants who answered the question on the number of sexual partners they have had (n = 78), 24.3 percent of them reported having five sexual partners in the last year. The lifetime number of sexual partners for 24.3 percent of the participants was 6 to 10. Another 12.8 percent had 11 to 20 sexual partners, 19.2 percent had 21 to 50 sexual partners, and 12.8 percent of the respondents had 50 or more lifetime sexual partners (see Table IX). Of the total number of participants (n = 119) who answered, 70.5 percent of them said that they presently are having sex with one partner.

TABLE IX
NUMBER OF SEXUAL PARTNERS

	Number of Sexual Partners	Number	Percent
In the last week	1	16	20.5
In the last month	1	12	15.3
	2	4	5.1
	5	2	1.2
In the last year	1	32	41
	2	16	20.5
	3	8	10.2
	4	3	3.8
	5	19	24.3
In your lifetime	2	6	7.6
	3	2	2.5
	4	8	10.2
	5	8	10.2
	6-10	19	24.3
	11-20	10	12.8
	21-50	15	19.2
	50+	10	12.8

n = 78

FACTORS INFLUENCING SEXUAL ATTITUDES AND PRACTICE

Most of the questions that were asked in the Men's Health Questionnaire were written to determine what factors influenced male participants' sexual attitudes and practices. The first group of these questions dealt with STDs. Just over a third (38.5 percent) of the

participants have had an STD, and the most common STD in this group was Chlamydia (33.3 percent). The next most prevalent STDs were gonorrhea (28.8 percent), and then venereal warts (20.0 percent) (see Table X).

TABLE X
FREQUENCY OF STDs IN MALE PARTICIPANTS

	1		2	
	Number	Percent	Number	Percent
Chlamydia	15	33.3	2	4.4
Gonorrhea	13	28.8	0	0.0
Venereal Warts	9	20.0	4	8.8
Syphilis	4	8.8	1	2.2
Other	3	6.6	2	4.4
Herpes	1	2.2	2	4.4

n = 45

When asked if they protected themselves from their partners' secretions, only 14.0 percent reported that they always did, while 85.9 percent sometimes or never protected themselves from their partners' bodily secretions (see Table XI).

TABLE XI
FREQUENCY OF BIRTH CONTROL USE AND
PROTECTION FROM SECRETIONS

	Birth Control Use		Protection	
	Number	Percent	Number	Percent
Never	18	16.0	50	43.8
Sometimes	7	6.2	48	42.1
Usually	7	6.2	N/A	N/A
Almost always	21	18.7	N/A	N/A
Always	59	52.6	16	14.0

n = 112

Not using protection can also be seen by comparing those who have had an STD by whether or not they protect themselves from their partners secretions. Of those who have had an STD, 15.5 percent never protected themselves, and of those who reported always protecting themselves, only 2.7 percent had had an STD (see Table XII).

TABLE XII
HISTORY OF STDs AND FREQUENCY OF PROTECTION USED

	Never Use Protection		Sometimes Use Protection		Always Use Protection	
	Number	Percent	Number	Percent	Number	Percent
Had STD	17	15.5	21	19.2	3	2.7
No STD	29	26.6	27	24.7	12	11.0

n = 109

When asked what method participants used to protect themselves during sexual activity, more than three-fourths (78.3 percent) said that they used condoms (see Table XIII).

TABLE XIII
METHOD OF PROTECTION USED

	Number	Percent
Condom	76	78.3
Other	17	17.5
Latex barrier (Dental Dam)	2	2.0
Gloves	1	0.8
Spermicide	1	0.8

n = 97

CONTRACEPTIVE USE

The next group of questions dealt with conception and contraception. Just over half (52.6 percent) of the males said that they always practice birth control (see Table XI).

Most of the participants said that they either used condoms (53.7 percent) or their sexual partners used the pill (63.7 percent) (see Table XIV).

TABLE XIV
METHOD OF BIRTH CONTROL USED

	Number	Percent
Pill	51	63.7
Condoms	43	53.7
Diaphragm	18	22.5
None	16	20.0
Other	11	13.7
Foam	8	10.0
Sterilization	6	7.5
Rhythm	3	3.7
Withdrawal	2	2.5
IUD	1	1.2

n = 80

Of the males who answered the question about conception (n = 114), 39.4 percent of them had gotten a female pregnant. And, of the males who answered the question about the results of that pregnancy (n = 55), 40.0 percent said that the mother kept the child, and 34.0 percent said the result of the pregnancy was abortion (see Table XV).

TABLE XV
GOTTEN A FEMALE PREGNANT AND
RESULTS OF PREGNANCY

	Number	Percent
Gotten a Female Pregnant (n = 114)		
Yes	45	39.4
No	61	53.5
Do not know	8	7.0
Results of Pregnancy (n = 50)		
Mother kept child	20	40.0
Abortion	17	34.0
Other	9	18.0
Marriage	4	8.0
Adoption	0	0.0

Most (73.1 percent) of the male participants in this survey said that they have used drugs, and 9.1 percent of the males said they had also injected drugs with needles. When asked if while under the influence of drugs or alcohol they forget to use a condom or some other form of protection, 40.5 percent said they had (see Table XVI)

TABLE XVI
USED/INJECTED DRUGS AND WHETHER
PROTECTION WAS USED

	Number	Percent
Used drugs (n = 119)		
Yes	87	67.4
No	32	24.8
Injected drugs (n = 120)		
Yes	11	8.5
No	109	84.5
Forgot to use protection when using drugs/alcohol (n = 106)		
Yes	43	40.5
No	63	59.4

Of the males who had an STD in the past, 34.9 percent also used drugs. And, of those who used drugs and forgot to use protection, 44.1 percent also previously had had an STD (see Table XVII).

TABLE XVII
PARTICIPANTS WITH STDs WHO USED DRUGS OR
FORGOT TO USE PROTECTION

	STD		No STD	
	Number	Percent	Number	Percent
Drugs (n = 114)				
Yes	37	32.4	48	42.1
No	7	6.1	22	19.2
Forgot (n = 100)				
Yes	19	44.1	21	48.8
No	24	38.0	36	51.1

Sexual abuse was also found in this group of males. Most (95.8 percent) said they had not forced or coerced anyone into having sex, although 4.1 percent, or five of the participants, said they had forced or coerced someone into sex. A larger number of the participants (11.7 percent) said they had been forced or coerced into having sex with someone else. A majority (70.8 percent) of the participants indicated that they do not have guilty feelings about having sex, but 19.1 percent sometimes feel guilty about sex. And, finally, just over half (56.6 percent) of the participants completing the questionnaire indicated that they would be interested in a free supply of condoms (see Table XVIII).

TABLE XVIII

FACTORS INFLUENCING SEXUAL ATTITUDES AND PRACTICE

	Yes		No		Sometimes	
	Number	Percent	Number	Percent	Number	Percent
Have forced/coerced sex (n = 120)	5	4.1	115	95.8	N/A	N/A
Been forced/coerced into sex (n = 119)	14	11.7	105	88.2	N/A	N/A
Have guilt about sex (n = 120)	12	10.0	85	70.8	23	19.1
Interested in supply of condoms (n = 120)	68	56.6	52	43.3		

CLACKAMAS COUNTY HEALTH CLINIC UTILIZATION

Several of the questions on the survey asked about services offered at the Clackamas County Health Clinic. Most of the male participants (71.4 percent) said that if they needed birth control information or treatment for an STD, they would go the health department (see Table XIX).

TABLE XIX
WHERE PARTICIPANT WOULD SEEK
INFORMATION OR TREATMENT

	Number	Percent
Health Department	80	71.4
Doctors office	18	16.0
Do not know	8	7.1
School clinic	4	3.5
Planned Parenthood	2	1.7

n = 112

Less than half of these males (42.6 percent) had previously been to the county health department. The participants were asked to choose what services that are provided at Clackamas County Health Department they would be interested in receiving. Getting a sports or job physical was the number one choice (64.8 percent) for the participants. Seeing a doctor or nurse about a sexual or IV drug use related infection was identified by 48.8 percent of the males as a service they would seek. And, 45.6 percent said they would go to the health clinic for a general health problem (see Table XX).

TABLE XX

SERVICES OFFERED AT CLACKAMAS COUNTY PUBLIC
HEALTH DIVISION THAT PARTICIPANTS WOULD
BE INTERESTED IN RECEIVING

	Number	Percent
See doctor or nurse about an infection from sex or IV drug use	61	48.8
See a doctor or nurse about general health problems	57	45.6
Have a job physical	48	38.4
Get a supply of condoms	43	34.4
Get birth control information	36	28.8
Cholesterol test	35	28.0
Have a sports physical	33	26.4
Blood pressure check	27	21.6
Stop smoking group	25	20.0
Talk about sex problems	18	14.4
Find out about getting sterilized (vasectomy)	9	7.2
Other	8	6.4

n = 125

The participants were also asked to identify reasons why they thought men do not use the services provided by the Clackamas County Health Department. The number one reason identified by the participants (64.8 percent) was that they thought that males were too embarrassed to come into the clinic. Other reasons included that they thought it was a women's clinic (40.8 percent), they could not afford it (32.0 percent), they thought that they needed a parent's consent (7.2 percent), or they went to their personal physician (32.8 percent) (see Table XXI).

TABLE XXI

REASONS WHY PARTICIPANTS THOUGHT MEN DO NOT USE
THE SERVICES PROVIDED BY THE CLACKAMAS
COUNTY HEALTH DEPARTMENT

	Number	Percent
Too embarrassed to come in	81	64.8
Think it is a women's clinic	51	40.8
Other	43	34.4
Go to a personal physician	41	32.8
Think they can't afford to pay for care	40	32.0
Can't come during daytime hours	25	20.0
Don't have a ride to get there	9	7.2
Think that they need a parent's consent first	9	7.2

n = 125

CHAPTER V

RESEARCH QUESTIONS ANSWERED, DISCUSSED, AND RECOMMENDATIONS FOR FUTURE RESEARCH

RESEARCH QUESTIONS

Demographics

What are the demographics of the males who completed the Men's Health Questionnaire at the Clackamas County Health Department?

The average age of the male participants who responded to the Men's Health Questionnaire was 22.8 years old. The range of ages was 15 to 40, with 50 percent of the males between the ages of 17 and 21.

Most (94.4 percent) were white males and non-students (76.0 percent). Of the males who were employed, 29.2 percent of them worked in construction and 15.7 percent were involved in sales of some sort. Just over half (53.6 percent) of the males have never been married, and most live with their parents (25.8 percent) or with relatives (20.8 percent). Most indicated that they do not have a religious preference, and the majority (72.5 percent) never or rarely attend church.

The number of males ages 15 to 19 in Clackamas County is estimated to be 11,330 (Murphy, 1989). This study only questioned 39 of this group of males; that is, one out of every 290 males in Clackamas County in this age group answered the Men's Health Questionnaire. Efforts to increase the number of males answering the Men's Health

Questionnaire would be needed in order to increase the generalizability of the information obtained.

Sexual Attitudes and Beliefs

What are the sexual attitudes and beliefs of the males who completed the Men's Health Questionnaire regarding contraceptives and their use, and sexually transmitted diseases?

The majority (84.0 percent) of the respondents said that sharing contraceptive responsibilities with their partner was something that they believed in doing. The majority (76.8 percent) of participants said that "saying no" was the most effective birth control method. It was not determined if it is the males or females who say no, if it is a joint agreement, or if they follow through with saying no.

Most of the males thought that condoms reduced pleasure too much, but when they used condoms they felt protected. Several reasons that would make it more likely for this group of males to use condoms included fear of AIDS (25.3 percent), partner's requested (10.6 percent), if they got a new partner (10.6 percent), and if condoms did not reduce pleasure (10.6 percent). These responses are consistent with other research on condom use (St. Lawrence and Kelly, 1989). Males in this sample indicated that they had talked to their parents about sex. It is not known who initiated the conversation, but of those who had talked to their parents about sex, less than half (48.7 percent) were comfortable with that conversation. This too is consistent with past research that says parents do not talk to their children about sex (Swan, 1980).

Sexual Experiences and Practices

What are the sexual experiences and practices of males who completed the Men's Health Questionnaire?

Most (87.8 percent) of the males in this study indicated that their sexual orientation was heterosexual; 5.6 percent said they were bisexual; and 2.4 percent said they were homosexual by orientation. The national estimates are 70 percent, 20 percent, and 10 percent, respectively (Remafedi, 1987). This difference may be due to the fact that the age of this group of males is young and they have not yet determined their actual sexual preference. It may also be due to the fact that Clackamas County is suburban and rural, where sexual preference is less likely to be admitted (Remafedi, 1987). It also may be that those who identify themselves as bisexual or homosexual are utilizing other clinics.

The average age for this group of males to experience their first orgasm was 13.8 years old. The average age for first intercourse was 14.8 years old, with 54.2 percent of the males experiencing intercourse for the first time between the ages of 13 and 16. This is consistent with other research in this area (Sonenstein, Pleck, and Ku, 1989; Marsiglio, 1986; Hofferth, Kahn, and Baldwin, 1987; Elliott, 1989). Most (97.4 percent, $n = 117$) of the males had experienced sex with a female. Only two males had experienced sex with another male, and only one had experienced sex with both.

Of the participants who answered the question on the number of sexual partners they have had ($n = 79$), 24.3 percent of them ($n = 78$) had had five sexual partners in the last year. The lifetime number of sexual partners for 24.3 percent of the participants was 6 to 10. Another 12.8 percent had had 11 to 20 sexual partners; 19.2 percent had had 21 to 50 sexual partners; and 12.8 percent of the respondents had had 50 or more sexual partners. The research indicates that having unprotected anal or vaginal sex with multiple partners places one at a greater risk of STDs. This would suggest that many of these men are at risk in terms of acquiring STDs, including HIV (Reiss and Leik, 1989).

Factors Influencing Sexual Attitudes and Practices

What factors may have contributed to the sexual attitudes and practices of the males who completed the Men's Health Questionnaire?

There are a number of different factors that seem to have an influence on the sexual attitudes and sexual practices of the males in this study. In terms of STDs, just over a third (38.5 percent) of the subjects have had an STD in the past and 43.8 percent of the males reported never protecting themselves from their partners' bodily secretions. Of men males who have had an STD, 15.5 percent do not protect themselves from bodily secretions.

Just over half (52.6 percent) of the males said they always use contraceptives, which were either condoms (53.7 percent) or the pill (63.7 percent). Whether pregnancy was a desired outcome or not, 39.4 percent had gotten a female pregnant. Thirty-four percent of these pregnancies ended in abortion. One of the reasons why these unwanted pregnancies may have occurred is the use of drugs. A third (33.3 percent) of the males who used drugs also forgot to use contraception. Likewise, 44.1 percent of those who used drugs and forgot to use protection also had an STD. Although it is not known if the time they used drugs and forgot protection was also the time they got the STD, the possibility is very real.

More males (11.7 percent versus 4.1 percent) indicated that they had been sexually forced or coerced in the past than those who said they have forced or coerced someone sexually. The number of males who have been forced or coerced into sexual behavior, according to Bruess and Greenberg (1988) is about one out of every twelve males. In this study, one out of every 8.5 males had been forced or coerced into sexual activity.

One out of every 24 males indicate that they have forced or coerced another person into sexual behavior. National estimates of the number of males who commit rape according to Ageton (1983) is one out of every five hundred males ages 12 to 20 years old. Under-

reporting of the occurrences of rape by the perpetrator of the rape is likely, in that arrest is the probable outcome if others find out about the rape. Another problem with the reported number of rapes is just that they are only the reported cases. Estimates that examine the numbers of rapes use different criteria to determine what constitutes rape. The numbers of people coerced into sex are generally not available because many people, both male and female, do not know it happened (Ageton, 1983).

Most (70.8 percent) of the males said that they do not have guilty feelings associated with having sex, and 19.0 percent said they sometimes feel guilty about having sex. Jourard and Landsman (1980) say that guilt is a response people have to violating their personal moral code. Much of this guilt is not because of behavior, but rather because of sexual thoughts and desires. As Bruess and Greenberg (1988) point out, people should not feel guilty about sexual thoughts because having sexual thoughts and desires is a natural part of sexuality. The development of a sense of morality, in terms of sexuality, must allow people to have sexual thoughts and desires without feeling guilty for having them. The only place for guilt in sexuality is when people's sexual thoughts and desires become sexual behavior that is not consensual.

Health Clinic Utilization Preferences

What services would the participants be interested in receiving at the Clackamas County Health Department?

The number one reason males in this study said they would come to the Clackamas County Health Department is for a job or sports physical. Other reasons males would come into the clinic would be to have a check up for an STD (48.8 percent) or a general health problem (45.6 percent). The number one reason why men do not come into the clinic, according to the respondents, is because they are embarrassed (64.8 percent).

Given the list of services that are offered at the clinic, the males who answered the questionnaire were asked to identify which of the services they would be interested in using at some future time. The responses were as follows:

TABLE XXII

SERVICES OFFERED AT CLACKAMAS COUNTY PUBLIC
HEALTH DIVISION THAT PARTICIPANTS WOULD
BE INTERESTED IN RECEIVING

	Number	Percent
See doctor or nurse about an infection from sex or IV drug use	61	48.8
See a doctor or nurse about general health problems	57	45.6
Have a job physical	48	38.4
Get a supply of condoms	43	34.4
Get birth control information	36	28.8
Cholesterol test	35	28.0
Have a sports physical	33	26.4
Blood pressure check	27	21.6
Stop smoking group	25	20.0
Talk about sex problems	18	14.4
Find out about getting sterilized (a vasectomy)	9	7.2
Other	8	6.4

n = 125

RECOMMENDATIONS FOR FUTURE RESEARCH

1. Modify the questionnaire to include questions about the initiation and the type of sex information received from parents, as well as information received in sex education classes.

2. Develop a comprehensive assessment questionnaire that can help identify education strategies that may address negative attitudes and inaccurate beliefs about men's sexuality. Include questions about sexual desires, definitions of masculinity and femininity subscribed to by males, and their attitudes towards women. Also test the assessment instrument's effectiveness.

3. Conduct research comparing males who receive comprehensive education on sexuality as outlined in the education strategies section (Chapter II), and males who receive superficial sex information. Specifically, look at whether or not the comprehensive information decreases the numbers of teenage pregnancies and STDs, and if sexual attitudes and behaviors are changed due to this difference in education received.

4. The questions used in this study were not validated. They should be validated prior to the questionnaire being used again.

5. Obtain data in more diverse settings, such as health clubs, health maintenance organizations, doctors' offices, churches, and other non-clinic settings, collecting data from a large cross-section of males in order to increase generalizability.

6. Examine the relationship between the expression of male sexual orientation and predominate concepts of masculinity.

7. Conduct a study asking sexual partners questions about the other partner's sexual behaviors. Compare responses with each partner's own identified sexual behaviors.

8. Develop a decision-making skills curriculum that provides motivation-building and attitude-changing exercises to assess personal risk with respect to conception and STDs, and test its effectiveness.

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APPENDIX A

CHARACTERISTICS OF SEXUAL HEALTH IN ADOLESCENTS

Body image awareness:

- He:
- Feels good about being male.
 - Understands how the male and female reproductive systems function.
 - Has a realistic and positive image of his body.
 - Is not obsessively concerned with dress and appearance.
 - Understands the stages of sexual development and how the body changes during the teen years.
 - Knows that sexual feelings are normal and can be controlled.
 - Knows his genital area and does not feel ashamed about his genitals.
 - Feels comfortable with bodily functions.
 - Is able to discuss the body without giggling or ridiculing.

Interpersonal relationships:

- He:
- Is able to communicate feelings to others without being embarrassed.
 - Is able to ask questions of parents and other adults about sex.
 - Is able to express affection.
 - Understands another person's viewpoint, e.g., boys and girls are able to understand each other.
 - Has respect for another's individuality.
 - Takes responsibility for his actions.
 - Is aware of personal needs and is able to assert them with a partner.
 - Knows his limits and is comfortable with setting limits.
 - Feels that he has positive things to offer in a relationship.

Decision-making:

- He:
- Is able to decide what is *right* for himself and acts in own best interests.
 - Is able to assess risk in any situation and make decisions based on the amount of risk he is willing to assume.

- Has a sense of the future and is planning for it.
- Has decided ahead of time what is or is not okay for him sexually.
- Has confidence in himself based on accurate knowledge.
- Has a clear sense of his values and acts in congruence with those values.

Sexual intimacy:

- He:
- Feels good enough about himself not to have early sexual experiences in order to prove his sexuality.
 - Understands that sexuality is more than just intercourse.
 - Understands the consequences of sexual activity.
 - Understands the difference between sexual feelings and love.
 - Is able to experience sexual intimacy whether or not he has intercourse.
 - Has accurate knowledge of birth control (and STDs) and has the ability to talk with a partner about it and to use it before having intercourse.
 - Knows that one can feel aroused and excited and yet have reasons for saying "no" to intercourse.
 - Knows that one's feelings deserve respect from others.
 - Is able to accept refusal for sex without feeling hurt.
 - [Has knowledge about sexual pleasure, sexual satisfaction and gratification, and orgasm.]

Source: Brick, P. "Toward a Positive Approach to Adolescent Sexuality." *Siecus Report* 17.5, May/July 1989, pp. 1-3.

*This list of characteristics can also be applied to females.

APPENDIX B

PREVENTIVE BEHAVIOR SEQUENCE

Preventive Behavior Sequence

Teenagers must be taught the following behavioral skills and encouraged to practice them. They must:

1. Accept their sexuality. Adolescents must acknowledge the fact that they are sexual beings who are likely in the future to become sexually involved.
2. Learn relevant sex-related preventive information. First teenagers must acquire information that helps them to make an objective assessment of their degree of pregnancy and STD/HIV risk. Second, teenagers must learn information about specific preventive behaviors.
3. Make an active decision to engage in preventive behaviors.
4. Bring up and negotiate sex-related prevention with their partners.
5. Perform more or less public sex-related preventive acts (condom purchasing, HIV testing).
6. Consistently practice sex-related preventive behaviors and reinforce themselves and their partners for practicing prevention.
7. Be able to shift preventive scripts. That is to know alternatives in different situations.

Source: Fisher, W. "All Together Now: An Integrated Approach to Preventing Adolescent Pregnancy and STD/HIV Infection." *Siecus Report* 18.4, April/May 1990, pp. 1-11.

APPENDIX C

AARM MODEL

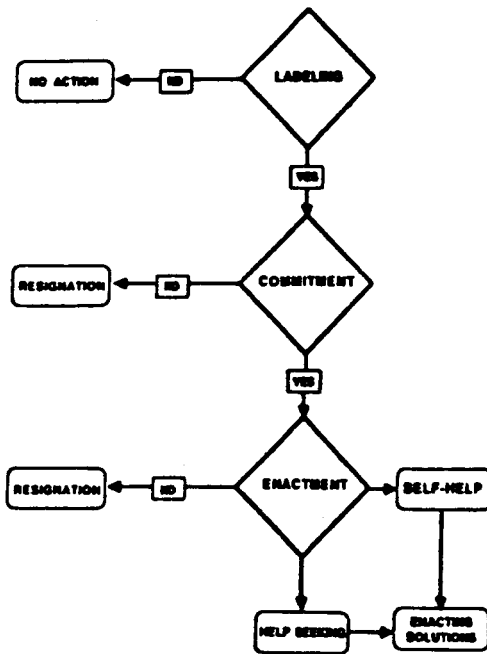


Figure 1. Overview of ARRM stages.

Stage	Some [Hypothesized] Influences	Outcome Indicators
One : Labeling	Susceptibility Trans. Know. Aversive Emotions • Social Factors	Is your sexual behavior putting you at risk for HIV infection?
Two : Commitment	Aversive Emotions Perceptions of: enjoyment risk reduction Self-Efficacy • Social Factors	Do you expect to do "it" in the next 4 weeks?
Three : Enactment	Aversive Emotions Sexual Communication Help-Seeking • Social Factors	What have you done?

* networks, norms

Figure 2. Aids risk reduction model—Influences.

APPENDIX D

ELLIS (1962) IRRATIONAL BELIEFS

Irrational Beliefs

Ellis (1962) identified a list of typical irrational beliefs that people might have. He believes it is a mistake for people to evaluate or rate themselves beyond the idea that everyone is a fallible human being.

This list includes the following:

1. The idea that it is a dire necessity for adult human beings to be loved or approved by virtually every significant other person in his community.
2. The idea that one should be thoroughly competent, adequate, and achieving in all possible respects if one is to consider oneself worthwhile.
3. The idea that certain people are bad, wicked, or villainous, and that they should be severely blamed and punished for their villainy.
4. The idea that it is awful and catastrophic when things are not the way one would like them to be.
5. The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrow and disturbances.
6. The idea that if something is or may be dangerous or fearsome, one should be terribly concerned about it and should keep dwelling on the possibility of its occurring.
7. The idea that it is easier to avoid than to face certain life difficulties and self-responsibilities.
8. The idea that one should be dependent on others and need someone stronger than oneself on whom to rely.
9. The idea that one's past history is an all-important determinant of one's present behavior and that because something once strongly affected one's life, it should indefinitely have a similar effect.

10. The idea that one should become quite upset over other people's problems and disturbances.

11. The idea that there is invariably a right, precise, and perfect solution to human problems and that it is catastrophic if this correct solution is not found.

Source: Ellis, A. *Reason and Emotion in Psychotherapy*. New York: Lyle Stuart, 1962.

APPENDIX E

CONDOM USE: USER INSTRUCTIONS

User Instructions

Why should you use condoms?

1. To prevent an unwanted pregnancy.
2. To protect yourself and your partner against sexually transmitted infections, including HIV.
3. To protect women against infertility and cervical cancer.
4. To protect the fetus during pregnancy against HIV infection, gonorrhea, herpes, chlamydia, trichomoniasis, and genital warts.

When should you use condoms?

Every time you have intercourse and you are afraid that an infection may be spread from one partner to the other, even during pregnancy. (Since you do not know that someone has a STD, it is best that a condom be used every time.)

How do you use a condom?

1. Put the condom on the erect penis (either partner can do this) BEFORE the penis is inserted into the vagina or anus.
2. Wait until the vagina is well lubricated, or use lubricant in the vagina and anus, because a condom can tear if the vagina or anus is dry.
3. Roll the condom all the way to the base of the erect penis.
4. Leave one-half inch of empty space at the tip of the condom (pinch the tip as you roll it on to make sure no air is trapped inside).
5. Condoms can tear, so be careful.
6. If extra lubrication is needed, use water or a water-based lubricant, like K-Y jelly, or contraceptive foam, gel, or cream. DO NOT use petroleum jelly, shortening, or other petroleum-based agents that weaken rubber.
7. For extra protection, use a backup method of birth control such as a diaphragm; contraceptive foam, gel, or suppositories with HIV killing agent; the sponge; or the pill.

How do you remove the condom?

1. After intercourse, withdraw the penis immediately, holding on to the rim of the condom to prevent spilling.

2. Check the condom for tears, then throw it away after you tie a knot in the end holding the contents inside. If the condom is torn, quickly insert spermicidal foam or gel.
3. Store condoms in a cool, dry place. Heat, even body heat, may cause the rubber to weaken. If condoms are kept out of the sunlight and fluorescent light, they can last up to five years. Be sure to check the expiration date.

Source: Hatcher, R. "The Truth About Condoms." *Siecus Report* 17.2, November/December 1988, pp. 1-9.

APPENDIX F

SAFER SEX GUIDELINES

Safer Sex Guidelines

Safe or very low risk activities which present the least likelihood of STD/HIV transmission.

Probably safe or possible risky activities which contain elements of possible risk or about which there is insufficient knowledge and information.

Unsafe activities which have been clearly linked to STD/HIV transmission.

Safe or Very Low Risk

- Sexual fantasies of any kind
- Sex talk (romantic, simply informational, or "talking dirty")
- Flirting
- Hugging
- Social (dry) kissing
- Phone sex
- Bathing together (including erotic bathing)
- Body massage (including erotic and non-genital oral massage)
- Smelling bodies and body fluids
- Tasting your own body fluids
- Licking (on healthy, clean skin)
- Consensual exhibitionism and voyeurism (showing off and watching)
- Masturbation (mutual or solitary--penile, vaginal, clitoral)
- Using personal sex toys
- S&M games (without bruising or bleeding)
- Sensuous feeding
- Sex movies, videos, and tapes
- Erotic books and magazines
- Live sexual entertainment

Probably Safe, Possible Risky

- French kissing
- Fellatio without ejaculation (safer with a condom)
- Fellatio with ejaculation wearing a condom
- Cunnilingus (oral-vaginal sex, safer with a latex barrier and/or spermicide)
- Peno-vaginal intercourse with a condom (safer with spermicide, safer yet when combined with a cervical barrier-diaphragm, cap, or sponge)
- Digital-anal sex with glove (ass play with latex or plastic glove)
- Anal intercourse with condom (safer to withdraw before ejaculation)
- Anilingus with latex (anal-oral sex, rimming through a rubber dam or condom)
- Contact with urine (golden showers or water sports on unbroken skin)

Unsafe

- Vaginal intercourse without a condom
- Anal intercourse without a condom
- Swallowing semen
- Receiving semen vaginally
- Unprotected oral-anal contact
- Unprotected manual-anal intercourse (fisting without a latex glove)
- Unprotected manual-vaginal intercourse (fisting without a latex glove)
- Sharing menstrual blood
- Sharing needles or blood while piercing or shooting drugs

Risk increases with the number of partners in unprotected activities. Risk increases when people are drunk or high on drugs.

Source: McIlvenna, T. (Ed.). *The Complete Guide to Safe Sex*. Beverly Hills, CA: Institute for Advanced Study of Human Sexuality, 1987.

APPENDIX G

SURVEY QUESTIONS

QUESTIONNAIRE INSTRUCTIONS

Thank you for taking the time to fill out this questionnaire. The purpose of this questionnaire is to find out what services men need. Filling out the questionnaire will not affect the services you receive at the health division. Please answer the questions honestly and by yourself. Please DO NOT put your name on this questionnaire, so nobody will know who filled it out. We DO NOT need to know your name.

A male counselor is available to take your blood pressure and to answer any questions you might have. Would you be interested? ☐ Yes ☐ No

They can also provide you with a supply of free condoms. Would you be interested?
☐ Yes ☐ No

Did you see a doctor or a nurse before you filled out this questionnaire?
☐ Yes ☐ No

Why did you come to the health department?

- ☐ a. For own appointment.
- ☐ b. Accompanying marital/sexual partner.
- ☐ c. Came with a friend.

When you are finished answering all of the questions, please return the questionnaire to the front desk.

Thank you

MEN'S HEALTH QUESTIONNAIRE

General Information:

1. Age _____
2. Are you a student? ☐ Yes ☐ No
3. Are you employed? ☐ Yes ☐ No
4. Occupation _____
5. Race:

<input type="checkbox"/> White	<input type="checkbox"/> Black
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian
<input type="checkbox"/> American Indian	<input type="checkbox"/> Pacific Islander
	<input type="checkbox"/> Other _____
6. What is your zip code? _____
7. What is your marital status?

<input type="checkbox"/> Never married	<input type="checkbox"/> Separated
<input type="checkbox"/> Engaged	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Spouse deceased
8. What is your living status?

<input type="checkbox"/> Live alone	<input type="checkbox"/> Live with relative(s) other than parents
<input type="checkbox"/> Live with parents	<input type="checkbox"/> Live with sexual partner
<input type="checkbox"/> Single parent (with children)	<input type="checkbox"/> Live with marital partner
<input type="checkbox"/> Live with friends	<input type="checkbox"/> Other _____
9. Religious Preference

<input type="checkbox"/> Protestant	<input type="checkbox"/> Catholic
<input type="checkbox"/> Jewish	<input type="checkbox"/> LDS
<input type="checkbox"/> None	<input type="checkbox"/> Other _____

10. How often do you attend church?

☐ Never

☐ Often

☐ Rarely

☐ Always

☐ Sometimes

11. Have you or did you ever talk about sexual intercourse with your parents?

☐ Yes ☐ No

12. Do you or did you feel comfortable talking about sexual intercourse with your parents? ☐ Yes ☐ No

13. When it comes to birth control, men should share the responsibility with women:

☐ Never

☐ Often

☐ Rarely

☐ Always

☐ Sometimes

14. What method of birth control is 100% effective?

☐ Pill

☐ Saying No

☐ I.U.D.

☐ Don't Know

☐ Condoms

15. If you or a friend needed birth control information or treatment for a sexually transmitted disease, where would you go? _____

16. Have you ever visited the county health department? ☐ Yes ☐ No

If yes, what was the reason(s) for the visit? _____

17. Of the many services offered at the Clackamas County Public Health Division, which one(s) do you think you might use?

- | | |
|--|--|
| <input type="checkbox"/> stop smoking group | <input type="checkbox"/> blood pressure check |
| <input type="checkbox"/> cholesterol test | <input type="checkbox"/> get a supply of condoms |
| <input type="checkbox"/> see a doctor or nurse about an infection from I got from sex or IV drug use | <input type="checkbox"/> get birth control information |
| <input type="checkbox"/> find out about getting sterilized (a vasectomy) | <input type="checkbox"/> talk about sex problems |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> have a sports physical |
| | <input type="checkbox"/> see a doctor or nurse about general health problems |

18. What are some of the reasons you think men don't use the services at the county health department? You can pick more than one:

- ☐ think they can't afford to pay for care
☐ think it is a women's clinic
☐ don't have a ride to get there
☐ can't come during daytime hours
☐ too embarrassed to come in
☐ think they need a parent's consent first
☐ don't think they need any of the services offered
☐ go to a personal physician
☐ other reasons _____

19. Have you ever examined your own genitals? ☐ Yes ☐ No

20. Are you primarily sexually attracted to persons of the:

- ☐ same sex (homosexual)
☐ other sex (heterosexual)
☐ either sex (bisexual)

Sexual Experience and Practices:

21. How old were you when you experienced your first orgasm? _____

22. Have you had *any* sexual experiences with a partner? ☐ Yes ☐ No

If no, at what age do you plan on having sex for the first time? _____

23. If you have never had intercourse, have you ever engaged in petting with a partner to orgasm? ☐ Yes ☐ No

• • • **STOP HERE** if NO was the answer to question 22 • • •

24. Have you had any sexual experience:

with a female? ☐ Yes ☐ No

with a male? ☐ Yes ☐ No ☐ Both

25. How old were you when you first experienced intercourse:

with a female? _____

with a male? _____

26. With how many people have you engaged in sexual relations:

	Female	Male
In the last week?		
In the last month?		
In the last year?		
In your lifetime?		

27. At the present time, are you having sex with one partner? ☐ Yes ☐ No
If yes, for how long? _____

28. Do you or your partner practice some form of birth control? ☐ Yes ☐ No

29. What form of birth control are you or your partner now using?

☐ None

☐ Foam

☐ Condoms

☐ Withdrawal

☐ Sterilization

☐ Rhythm

☐ I.U.D.

☐ Pills

☐ Diaphragm

☐ Other _____

30. How often do you or your partner practice birth control:
- | | |
|------------------------------------|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> Almost always |
| <input type="checkbox"/> Sometimes | <input type="checkbox"/> Always |
| <input type="checkbox"/> Usually | |
31. Have you ever gotten a female sexual partner pregnant outside of marriage?
- ☐ Yes ☐ No ☐ Do not know
32. If you have been involved in a pregnancy outside of marriage, what was the result?
- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Mother kept child | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Adoption |
| <input type="checkbox"/> Other _____ | |
33. Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
34. Which sexually transmitted disease have you had?
- | | |
|------------------------------------|---|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Venereal Warts |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Other _____ |
35. Do you protect yourself from your partners vaginal secretions, semen, or blood during sexual activity?
- ☐ Never ☐ Sometimes ☐ Always
36. What do you use to protect yourself during sexual activity?
- | | |
|---------------------------------|---|
| <input type="checkbox"/> condom | <input type="checkbox"/> latex barrier (Dental Dam) |
| <input type="checkbox"/> gloves | <input type="checkbox"/> spermicide |
| | <input type="checkbox"/> other _____ |
37. How do you feel about using condoms? Check all that apply to you.
- ☐ I feel protected when I do
- ☐ I like the feel of them
- ☐ I feel embarrassed about using them
- ☐ I think that they reduce pleasure
- ☐ I think that my partner does not like them
- ☐ Other(s) _____

38. What do you think would make you more likely to use condoms?

39. Have you used drugs or alcohol prior to or during sexual relations?

☐ Yes ☐ No

If yes, when you were under the influence of drugs or alcohol, did you ever forget to use a condom or some other form of protection? ☐ Yes ☐ No

40. Have you ever injected drugs with a needle? ☐ Yes ☐ No

41. Have you ever forced/coerced anyone to have a sexual relation with you?

☐ Yes ☐ No

42. Have you ever been forced/coerced to have a sexual relation with someone?

☐ Yes ☐ No

43. Do you have guilt about having sex? ☐ Yes ☐ No ☐ Sometimes

44. Did you respond honestly to the questions. ☐ Yes ☐ No

45. Would you be interested in a supply of condoms? ☐ Yes ☐ No

MEN WHO DECLINED TO FILL OUT QUESTIONNAIRE

1. Age _____
2. Are you a student? ☐ Yes ☐ No
3. Are you employed? ☐ Yes ☐ No
4. Race:

<input type="checkbox"/> White	<input type="checkbox"/> Black
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian
<input type="checkbox"/> American Indian	<input type="checkbox"/> Pacific Islander
	<input type="checkbox"/> Other _____
5. What is your zip code? _____
6. Why did you come to the health department?
☐ For own appointment.
☐ Accompanying marital/sexual partner.
☐ Came with a friend.
7. What is your marital status?

<input type="checkbox"/> Never married	<input type="checkbox"/> Separated
<input type="checkbox"/> Engaged	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Spouse deceased

APPENDIX H

HUMAN SUBJECT REQUEST AND APPROVAL

PORTLAND STATE UNIVERSITY
PROTECTION OF HUMAN SUBJECTS INITIAL REVIEW

TO: Human Subjects Research Review Committee

FROM: Principal Investigator Russel Robbins

Department HPE Campus ext.# 4401

Date of Application November 28, 1990

Title of Proposed Study A Descriptive Study Of Adolescent And Young Adult
Male's Sexual Health Practices.


INVESTIGATOR'S ASSURANCES:

- A. I will promptly report changes in the proposed study and any unanticipated problems involving risk to subjects, including adverse reactions to the Human Subjects Research Review Committee. In the case of DHHS supported activities, I will also report these problems to the Department of Health and Human Services (through the respective granting office).
- B. I assure that documentary evidence of informed consent will be retained after the proposed study has been completed or discontinued for at least three years after that time.
- C. Since the Committee is obligated to periodically review this activity (at least annually) I will furnish it with relevant information when requested.
- D. I, the undersigned, will be responsible for the ethical standards of this project, and for protecting the rights and welfare of the subjects.


Signature of Principal Investigator

November 28, 1990
Date

I have read and approved this proposal:


Signature of Department Head

Nov 30, 90
Date

If this is part of a thesis/dissertation, the proposal must be approved PRIOR to Human Subjects Research Review Committee review.

XX Masters Thesis Doctoral Dissertation


Signature of Thesis/Dissertation Advisor

11/30/90
Date

OAA-GC/89

RECEIVED

NOV 30 1990

GRANTS & CONTRACTS

TITLE: A Descriptive Study of Adolescent and Young Adult Males' Sexual Health Practices.

PROSPECTUS

I. The purpose of this descriptive thesis is to identify characteristics of adolescent and young adult males' sexual health practices. The topics reviewed are sexual experience, contraceptive use, Sexually Transmitted Disease (STD) prevention practices, and to a limited extent, public health clinic utilization.

The data was collected from a 48-question, anonymous, self-administered questionnaire on men's sexual health practices. The questionnaires were collected by the Clackamas County Health Division. The questionnaire was distributed to all English speaking males between the ages of 15 and 40 who came into the Clackamas County Health Department during the months of June 1990 through October 1990. One hundred twenty-five completed questionnaires were collected.

The questionnaires covered demographic information as well as information about sexual experience, contraceptive use, STD prevention practices, and public health clinic utilization. Other related questions included familiarity with one's own sexual anatomy, attitudes about responsibility for sexual activity, and honesty in answering the questions on the survey.

Since this is not an experimental study, no cause and effect relationship will be examined.

This is the first review of this project.

II. Exemption categories number 3 and 5 apply to this project.

Under exemption number 3, the data that were collected was done in an anonymous setting. No identifying marker(s) or names were attached to the completed questionnaires. Even though the subject matter is sensitive in nature, the participants' names cannot be attached prospectively or retrospectively to any of the questionnaires.

Under exemption number 5, the data that will be used were already collected by the Clackamas County Health Division. Written informed consent was determined not to be needed if the following criteria was met: (a) participants were at least age 15, (b) participants' names were not attached to the questionnaire, and (c) it was made clear to the participants that participation in the survey, would not affect the services that they could or would receive at the Health Division.

III. Subject recruitment was accomplished by asking all English-speaking males between the ages of 15 and 40 to answer a questionnaire that would help the Health Division provide better services to men in the county. Those who declined to answer the questionnaire were asked selected demographic questions. This was done to determine if there was a difference between those that answered the questionnaires and those that declined to answer the survey.

IV. It was determined by the Research Review Committee of the Clackamas County Health Division that if the following criteria was met, there was not a need for informed consent: (a) participants were at least age 15, (b) participants' names were not attached to the questionnaire, and (c) it was made clear to the participants that participation in the survey, would not effect the services that they could or would receive at the Health Division.

V. I entered the building and went to the front desk to check in. I was asked by one of the counselors behind the counter if I would be willing to fill out a questionnaire. They told me not to put my name on the paper, and that by filling it out, the services I would receive would not be different. And, if I did not want to fill it out, that would be all right.

I filled out the questionnaire and returned it to the front desk.

VI. No personal risks were involved in answering the questions. No names, numbers, or dates were placed on the questionnaires. Therefore, none of the data can be attached to a named person.

VII. The benefits of this questionnaire's results will be to help Clackamas County develop appropriate services for men.

VIII. Anonymous questionnaires protect the subjects so there are no confidentiality problems. The information will be discussed in a generalized fashion, that is not referring to one subject, but to all the subjects in general.

**HUMAN SUBJECTS RESEARCH
REVIEW COMMITTEE**

MEMORANDUM

OFFICE OF GRANTS AND CONTRACTS

DATE: December 4, 1990
TO: Russel Robbins, HPE
FROM: Joan Shireman, Chair, HSRRC 1990-91
RE: Exemption from HSRRC review of your application entitled, "A Descriptive Study of Adolescent and Young Adult Male's Sexual Health Practices"

This memo is response to your application dated November 30, 1990. The study you describe is exempt. I will note in our files that no further review of your research proposal is required, stating that you may proceed with the study. Even with the exemption above, it is necessary by University policy to notify this committee of the proposed research and we appreciate your timely attention to this matter.

JS:jp

c. Office of Grants and Contracts
Dawn Graff-Haight

APPENDIX I

SURVEY RESULTS WITH QUESTIONS

RESULTS

The data was analyzed with the use of SPSS-X 3.1 IBM software. The data file contained 129 cases, and frequencies were obtained for all questions. The results are as follows:

General Information:

1. Age (n = 120):

Age	Number	Percent
15	1	0.8
16	2	1.6
17	12	10.0
18	10	8.3
19	14	11.6
20	12	10.0
21	12	10.0
22	6	5.0
23	8	6.6
24	7	5.8
15	6	5.0
26	5	4.1
27	5	4.1
28	7	5.8
29	4	3.3
30	3	2.5
31	1	0.8
32	0	0.0
33	0	0.0
34	1	0.8
35	0	0.0

Age	Number	Percent
36	1	0.8
37	2	1.6
37	2	1.6
38	1	0.8
39	0	0.0
40	1	0.8
40+	0	0.0

2. Are you a student?

3. Are you employed?

	Yes		No	
	Number	Percent	Number	Percent
Student (n = 125)	30	24.0	95	76.0
Employed (n = 125)	90	72.0	34	28.0

4. Occupation (n = 89):

	Number	Percent
Construction	26	29.2
Sales	14	15.7
Auto Repair	10	11.2
Steel worker	8	8.9
Restaurant	7	7.8
Farming	5	5.6
Other	19	21.3

5. Race (n = 125):

	Number	Percent
White	118	94.4
Hispanic	4	3.2
American Indian	3	2.4

6. Zip code (n = 111):

Zip Code	City	Number	Percent
97045	Oregon City	37	33.3
97222	Milwaukie	13	11.7
97068	West Linn	9	8.1
97267	Portland	9	8.1
97233	Portland	8	7.2
97015	Clackamas	7	6.3
97023	Estacada	5	4.5
97038	Molalla	4	3.6
97067	Welches	2	1.8
Other		17	15.3 (less than 1% in each zip code)

7. Marital status (n = 125):

	Number	Percent
Never married	67	53.6
Engaged	22	17.6
Married	26	20.8
Separated	2	1.6
Divorced	6	4.8
Spouse deceased	2	1.6

8. Living status (n = 120):

	Number	Percent
Live alone	10	8.3
Live with parents	31	25.8
Single parent	0	0.0
Live with friends	6	5.0
Live with relative	25	20.8
Live with sexual partner	5	4.1
Live with marital partner	21	17.5
Other arrangements	22	18.3

9. Religious preference (n = 119):

	Number	Percent
Protestant	15	12.6
Catholic	22	18.4
Jewish	1	0.8
LDS	1	0.8
Other	25	21.0
None	55	46.2

10. How often attend church (n = 124):

	Number	Percent
Never attend	37	29.8
Rarely attend	53	42.7
Sometimes attend	24	19.3
Often attend	8	6.4
Always attend	2	1.6

11. Have you or did you ever talk about sexual intercourse with your parents?
Yes 74/59.6% No 50/40.3% (n = 124)12. Do you or did you feel comfortable talking about sexual intercourse with your parents?
Yes 59/48.7% No 62/51.2% (n = 121)

13. When it comes to birth control, men should share the responsibility with women (n = 125):

	Number	Percent
Never	3	2.4
Rarely	1	0.8
Sometimes	8	6.4
Often	8	6.4
Always	105	84.0

14. What method of birth control is 100% effective (n = 125):

	Number	Percent
Pill	8	6.4
IUD	2	1.6
Condoms	9	7.2
Saying no	96	76.8
Do not know	10	8.0

15. If you or a friend needed birth control information or treatment for a sexually transmitted disease, where would you go (n = 112):

	Number	Percent
Health department	80	71.4
Doctors office	18	16.0
Do not know	8	7.1
School clinic	4	3.5
Planned Parenthood	2	1.7

16. Have you ever visited the county health department?
 Yes 52/42.6% No 70/57.3% (n = 122)

17. Of the many services offered at the Clackamas County Public Health Division, which one(s) do you think you might use (more than one choice possible) (n = 125):

	Number	Percent
Stop smoking group	25	20.0
Blood pressure check	27	21.6
Cholesterol test	35	28.0
See doctor or nurse about an infection from sex or IV drug use	61	48.8
Get a supply of condoms	43	34.4
Get birth control information	36	28.8
Find out about getting sterilized (a vasectomy)	9	7.2
Talk about sex problems	18	14.4
Have a sports physical	33	26.4
Have a job physical	48	38.4
See a doctor or nurse about general health problems	57	45.6
Other	8	6.4

18. What are some of the reasons you think men don't use the services at the county health department (n = 125):

	Number	Percent
Think they can't afford to pay for care	40	32.0
Think it is a women's clinic	51	40.8
Don't have a ride to get there	9	7.2
Can't come during daytime hours	25	20.0
Too embarrassed to come in	81	64.8
Think that they need a parent's consent first	9	7.2
Got to a person physician	41	32.8
Other	43	34.4

19. Have you ever examined your own genitals?

Yes 79/70.5% No 33/29.4% (n = 112)

20. Sexual orientation (n = 123):

	Number	Percent
Heterosexual	108	87.8
Bisexual	7	5.6
Homosexual	3	1.4

Sexual Experience and Practices:

21. How old were you when you experienced your first orgasm (n = 109):

	Number	Percent
U8	5	4.5
9	3	2.7
10	1	0.8
11	4	3.6
12	14	12.8
13	24	22.0
14	16	14.6
15	15	13.7
16	12	11.0
17	7	6.4
18	3	2.7
18+	5	4.5

22. Have you had *any* sexual experience with a partner?

Yes 115/96.6% No 4/3.3% (n = 119)

23. If you have never had intercourse, have you ever engaged in petting with a partner to orgasm?

Yes 34/68.0% No 16/32.0% (n = 50)

24. Have you had any sexual experience with a partner that is female, male, both (n = 117):

	Number	Percent
Female	114	97.4
Male	2	1.7
Both	1	0.8

25. How old were you when you first experienced intercourse (n = 112):

	Number	Percent
U8	6	5.3
9	1	0.8
10	0	0.0
11	1	0.8
12	7	6.2
13	15	13.3
14	20	17.8
15	16	14.2
16	19	16.9
17	10	8.9
18	6	5.3
19	7	6.2
20	2	1.7
21	1	0.8
22+	1	0.8

26. With how many people have you engaged in sexual relations (n = 78):

	Number of Sexual Partners	Number	Percent
In the last week	1	16	20.5
In the last month	1	12	15.3
	2	4	5.1
	5	2	1.2
In the last year	1	32	41
	2	16	20.5
	3	8	10.2
	4	3	3.8
	5	19	24.3
In your lifetime	2	6	7.6
	3	2	2.5
	4	8	10.2
	5	8	10.2
	6-10	19	24.3
	11-20	10	12.8
	21-50	15	19.2
	50+	10	12.8

27. At the present time, are you having sex with one partner?

Yes 84/70.5% No 35/29.4% (n = 119).

28. Do you or your partner practice some form of birth control?

Yes 87/78.3% No 24/21.6% (n = 111)

29. What form of birth control are you or your partner now using (n = 80):

	Number	Percent
None	16	20.0
Foam	8	10.0
Condoms	43	53.7
Withdrawal	2	2.5
Sterilization	6	7.5
Rhythm	3	3.7
IUD	1	1.2
Pill	51	63.7
Diaphragm	18	22.5
Other	11	13.7

30. How often do you and your partner practice birth control (n = 112):

	Number	Percent
Never	18	16.0
Sometimes	7	6.2
Usually	7	6.2
Almost always	21	18.7
Always	59	52.6

31. Have you ever gotten a female sexual partner pregnant outside of marriage?
 Yes 45/39.4% No 61/53.5% Do not know 8/7.0% (n = 114)

32. If you have been involved in a pregnancy outside of marriage, what was the result (n = 50):

	Number	Percent
Mother kept child	20	40.0
Abortion	17	34.0
Marriage	4	8.0
Adoption	0	0.0
Other	9	18.0

33. Have you ever had a sexually transmitted disease?

Yes 44/38.5% No 70/61.4% (n = 114)

34. Which sexually transmitted disease have you had (n = 45):

	One Time		Two or More Times	
	Number	Percent	Number	Percent
Gonorrhea	13	28.8	0	0.0
Syphilis	4	8.8	1	2.2
Chlamydia	15	33.3	2	4.4
Venereal Warts	9	20.0	4	8.8
Herpes	1	2.2	2	4.4
Other	3	6.6	2	4.4

35. Do you protect yourself from your partner's vaginal secretions, semen, or blood during sexual activity (n = 114):

	Number	Percent
Never	50	43.8
Sometimes	48	42.1
Always	16	14.0

36. What do you use to protect yourself during sexual activity (n = 97):

	Number	Percent
Condom	76	78.3
Latex barrier (Dental Dam)	2	2.0
Gloves	1	0.8
Spermicide	1	0.8
Other	17	17.5

37. How do you feel about using condoms (can answer more than once) (n = 119):

	Number	Percent
Feel protected	69	57.9
Like feel	7	5.8
Feel embarrassed	10	8.4
Reduce pleasure	74	62.1
Partner will not like	44	36.9
Other	15	12.6

38. What do you think would make you more likely to use condoms (can answer more than once) (n = 75):

	Number	Percent
Fear of STD	19	25.3
Partner requested	8	10.6
Did not reduce pleasure	8	10.6
Many partners	5	6.6
New partner	8	10.6
Thinner	4	5.3
None	6	8.0
Other	17	22.6

39. Have you used drugs or alcohol prior to or during sexual relations?

Yes 87/73.1% No 32/26.8% (n = 119)

If yes, when you were under the influence of drugs or alcohol, did you ever forget to use a condom or some other form of protection?

Yes 43/40.5% No 63/59.4% (n = 106)

40. Have you ever injected drugs with a needle?

Yes 11/9.1% No 109/90.8% (n = 120)

41. Have you ever forced/coerced anyone to have a sexual relation with you?

Yes 5/4.1% No 115/95.8% (n = 120)

42. Have you ever been forced/coerced to have a sexual relation with someone?

Yes 14/11.7% No 105/88.2% (n = 119)

43. Do you have guilt about having sex?

Yes 12/10.0% No 85/70.8% Sometimes 23/19.1% (n = 120)

44. Did you respond honestly to the questions?

Yes 109/93.9% No 7/6.0% (n = 116)

45. Would you be interested in a supply of condoms?

Yes 68/56.6% No 52/43.3% (n = 120)

Other Information Obtained:

Interested in talking with a counselor:

Yes 77/65.8% No 40/34.1% (n = 117)

Have you seen a doctor before you got this questionnaire?

Yes 20/17.3% No 95/82.6% (n = 115)

What was the purpose of today's visit (n = 29):

	Number	Percent
Own appointment	10	34.4
With partner	15	51.7
With friend	4	13.7