



CALIFORNIA STATE UNIVERSITY FULLERTON

Introduction

Sexual and reproductive health is a key factor in college health because research shows college students consistently underutilize condoms, placing them at risk for sexually transmitted infections (STIs) and unintended pregnancy.¹ STI infection rates are persistently high among college-age people (20-24 years).² Sex partners engaging in a dialog about sexual intercourse is associated with safer sexual behavior, like increased condom use and STI testing.³ Discussing these subjects can be difficult for young adults still learning to navigate relationships.⁴ Sexual communication is defined as a discussion of the following: past sexual history (STI diagnoses, unplanned pregnancy, number of partners), sexual desires, sexual boundaries, and anticipated contraception use (barriers and birth control).⁵

Methods

A survey was administered to students attending California State University, Fullerton. Data was collected using convenience sampling of students who approached the TitanWell Hut or table at campus events or attended TitanWell classroom presentations.

The survey asked questions about demographics, sexual communication self-efficacy (5 constructs), sexual behaviors (Condom Use & STI testing), health status (STI status, pregnancy, use of emergency contraception), and substance use. One hundred thirty students completed the survey, and 125 completed the SCSE

questions, which were used for analysis.

Sexual Communication Self-Efficacy Scale

The scale was comprised of 20-questions with Likert-type response categories. A value of 1 = "Very Difficult", 2 = "Difficult", 3 = "Easy", and 4 = "Very Easy".⁵ Cronbach's alpha for this scale is $\alpha = 0.93$, and once summed, the scores range from 20-80. Condom negotiation scores range from 3-12, and Cronbach's alpha for this subscale is $\alpha = 0.83$.

Five constructs were used in the scale to measure sexual communication. The constructs were contraceptive communication, positive sexual messages, sexual history, condom negotiation, and negative sexual communication.

For this analysis, we examined the condom negotiation construct and the composite sexual communication self-efficacy scores.

Statistical Analyses

Bivariate and multivariate analyses were performed using SPSS software v.29. Analysis of Variance (ANOVA) and independent samples t-tests were used to compare mean composite sexual communication score by gender, age, race/ethnicity, and sexual orientation. Two linear regression models were constructed with condom use negotiation and composite sexual communication score as dependent variables.

Results

- The mean age of the sample was 22 years old (SD=4.26 years, range 18-42 years). • Almost three-quarters of the sample participants identified as female gender
- (70.4%), 26.4% identified as male, and 2.4% identified as non-binary.
- The largest proportion of students were Hispanic/Latino (48.8%), followed by Asian/ Pacific Islander (22.4%), non-Hispanic White (12.8%), and Black/ African American (11.2%).
- Seventy-two percent of participants reported being heterosexual, 14.6% were bisexual, 4.1% were asexual, and 5.7% stated they were gay or lesbian.
- A majority, 75.8%, reported being sexually active currently or in the past.
- The average composite sexual communication score for this sample was 63.07 (SD = 11.79, range = 30 - 80).
- The average condom negotiation communication score for this sample was 10.11 (SD=1.94, range= 5 - 12).

Sexual Communication Self-Efficacy: A Pilot Study in College Students Samantha Doti, BS, and Jasmeet Gill, PhD, Department of Public Health, California State University, Fullerton

- Participants who identified with neither male nor female gender identity had the highest mean SCSES score of 65.25 followed by males at 63.71 and females at 61.03; F=0.672, p= 0.513).
- Non-Hispanic whites had the highest SCSES score at 65, followed by Hispanic/ Latino (=63.7) Black/ African American (=62.5), and Asian/ Pacific Islander (=60.31; F=0.537, p=0.709). The respondents that were left (multiracial, Native American /Alaskan Native, 'other' respondents, n=6) were pooled together for analysis. Their mean SCSES value was 64.5.
- Non-heterosexual participants had a higher mean SCSES score of 65.06 compared to heterosexuals at 62.54(t = , p = 0.280).
- Participants reporting frequent STI testing had a higher self-efficacy (mean SCSES score=65.69) than those with infrequent STI testing (mean= 61.21; F=, p=0.033).

Linear Regression

Sample Characteristics	Condom Negotiation (95% CI)	Composite Sexual Communication (95% CI)
Gender		
Male	Ref	Ref
Female	0.191 (-0.630, 1.012)	3.189 (-1.765, 8.144)
Non-binary	0.692 (-1.715, 3.099)	3.369 (-11.158, 17.895)
Race		
White	Ref	Ref
Black	0.171 (-1.271, 1.614)	-2.995 (-11.698, 5.708)
Hispanic/Latinx	-0.258 (-1.356, 0.840)	-0.554 (-7.180 <i>,</i> 6.071)
AAPI	-0.697 (-1.983, 0.589)	-4.005 (-11.768, 3.757)
Other	0.394 (-1.496, 2.283)	0.730 (-11.330, 11.476)
Age	-0.058 (-0.146, 0.030)	0.008 (-0.524, 0.540)
Sexual Orientation		
Heterosexual	Ref	Ref
Non-Heterosexual	0.129 (-0.711, 0.969)	3.221 (-1.848, 8.289)
STI Testing		
Less than once a year	Ref	Ref
At least once a year	0.303 (-0.439, 1.044)	3.761 (-0.715, 8.236)
 Participants who reported had a SCSES score 3,761 pc 	frequent testing for STIs	(testing at least once per year)

Confidence Interval (CI): -0.715, 8.236, p-value= 0.099).

- Participants who identified as non-Hispanic white had an average sexual communication self-efficacy value higher than those who identified as other races/ethnicities. The SCSES of Black/African American respondents was 2.995 points lower (95% CI:-11.698, 5.708, p-value=0.497), Hispanic/ Latino 0.554 points lower (-7.180, 6.071, p=0.869), and those who identified as Asian/Pacific Islander were 4.005 points lower (-11.768, 3.757, p-value =0.309). Participants who identified as another race/ethnicity averaged a value (0.073) lower than non-Hispanic white participants (-11.330, 11.476, p-value=0.990).
- Participants who identified with a sexual orientation besides heterosexual averaged a sexual communication self-efficacy score that was higher by 3.221 (-1.848, 8.289, p=0.211) than participants who identified as heterosexual.
- Age was associated with a slight increase in the average sexual communication self-efficacy value, 0.008 (-0.524, 0.540, p-value 0.029) for each year increase in age.

ANOVA

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This study's findings echo that of other studies focusing on sexual communication and improving health outcomes. Differences in demographic characteristics such as race/ethnicity, gender, and sexual orientation affect sexual communication and the likelihood of practicing safe sex. Female and non-binary individuals have higher SCSES scores than their male counterparts, and they are more likely to take on the responsibility of obtaining contraceptives.⁶ SCSES scores were also lower in Asian/Pacific Islander and Black/African American participants than in White/Caucasian, reflecting the health disparity where race/ethnicity acts as a predictor for negative sexual health outcomes because Non-Hispanic White participants have lower rates of STIs and unplanned pregnancies than other races/ethnicities.² Another study also found that Asian students had lower selfefficacy for gaining sexual consent and lower odds of consistent condom usage than other races/ethnicities.⁶

We observed interesting patterns between demographics, sexual behaviors, and sexual communication self-efficacy. Bivariate analysis showed that college students who tested for STIs more frequently were the individuals who were more comfortable communicating about sexual topics. However, after adjusting for possible confounders, this association was not statistically significant.

We lacked information on the number of past sexual partners, and we did not measure religious beliefs or cultural background. Our analysis also lacked statistical power due to the small sample size.

There is a gap in the literature looking at sexual communication self-efficacy in college students. More research should be done with larger samples of college students with an emphasis on addressing health disparities across different genders, sexual orientations, and race/ethnicities.

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Discussion

Conclusion

Limitations

Future Directions

References