

Exploring How Trauma Is Addressed in Sexual Education Interventions for Youth: A Scoping Review

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Abstract

Traumatic experiences are common among adolescents and can negatively affect learning and increase the risk of early pregnancy, parenthood, and sexually transmitted infections. Little is known about how current sexual health interventions address trauma. A scoping review was conducted to gain insight into how trauma is addressed in adolescent sexual health interventions. Peer-reviewed studies from the United States published between 2008 and 2018 describing a sexual health intervention for youth were considered. Studies were analyzed to determine if and how trauma was addressed in the interventions. Out of 169 articles initially screened, 29 met inclusion criteria and 23% ($n = 6$) addressed trauma. Four interventions addressed trauma in the intervention content, while two studies evaluated trauma in outcome measures. Educators can broaden this reach by developing trauma-informed content that is compatible with existing curricula. Ongoing study is recommended to evaluate the impact of trauma-informed content on the sexual knowledge, attitudes, and behaviors of youth.

Keywords

adolescent sexual health interventions, adverse childhood experiences, sexual health education, sexual violence, trauma-informed, victimization

Over 63% of Americans experience at least one adverse event in their childhood (Centers for Disease Control and Prevention [CDC], 2016). More specifically, 25% of women and 16% of men report experiencing sexual abuse in their childhood (CDC, 2016). A survey from the Children's Bureau (2018) reveals that 57,329 youth experienced sexual abuse in 2016, and an analysis of national data indicates that the lifetime experience of sexual abuse and sexual assault among 17-year-olds was 26.6% for girls and 5.1% for boys (Finkelhor et al., 2014). Late adolescence appears to be a time of particular vulnerability to sexual abuse and sexual assault, especially for girls, with rates rising from 16.8% when girls were 15 years old to 26.6% when they were 17 years old (Finkelhor et al., 2014). Sexual victimization has been consistently linked with sexual risk behaviors and negative sexual health outcomes, including, but not limited to, the transmission of sexually transmitted infections (STIs; Davis et al., 2018; Felitti et al., 1998). Individuals with a history of childhood sexual abuse tend to have more sexual partners (Littleton et al., 2007; Scheidell et al., 2017; Senn et al., 2012), are more likely to engage in transactional sex (Krisch et al., 2019; Lalor & McElvaney, 2010; Stroebel et al., 2012), and are less likely to use protection during sex

(Campbell et al., 2004; Homma et al., 2012) compared with their peers without histories of sexual victimization. More specifically, research into the impact of sexual abuse on adolescent development has found links between a history of sexual abuse, altered stress responses, and increased odds of early onset of puberty among girls (Foster et al., 2008; Shenk et al., 2010; Wise et al., 2009). In addition, adolescent girls who had been sexually abused also reported earlier initiation of sexual intercourse, greater preoccupation with sex, and lowered efficacy in using birth control (Noll et al., 2003). Among adolescent boys and girls, a history of child maltreatment has been associated with juvenile delinquency and substance abuse (Danielson et al., 2009; Feiring et al., 2007). Female and male adolescents with a history of maltreatment are more likely than their nonabused peers to have unhealthy

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and unfulfilling romantic and/or sexual relationships, as well as an amplified risk of experiencing dating violence, with a greater risk of perpetration among boys and victimization among girls (DiLillo et al., 2007; Wolfe et al., 2001). In addition, trauma is a strong predictor of adolescent pregnancy and parenthood (Anda et al., 2002; Noll et al., 2009).

Despite substantial resources from the Office of Adolescent Health being allocated to support the evaluation of teen pregnancy prevention programs (Farb & Margolis, 2016), little is known about how these programs address trauma. This is problematic given evidence that childhood trauma increases the likelihood of negative sexual health behaviors and outcomes. To address this gap, scholars have called for sexual health interventions that are trauma-informed (Faulkner, 2015; Fava & Bay-Cheng, 2013; Schladale, 2015). Such interventions would be grounded in the tenets of trauma-informed care (i.e., cultivating an environment of safety, cultural responsiveness, empowerment, trust, transparency, and collaboration; Substance Abuse and Mental Health Services Administration, 2014) and offer the benefits of an engaging, well-rounded sexual health educational experience for all adolescents, regardless of their trauma history (Faulkner, 2015; Fava & Bay-Cheng, 2013; Sales et al., 2016; Schladale, 2015). This scoping review examines peer-reviewed articles about adolescent sexual education interventions in order to understand how trauma is addressed and/or considered in their programming and evaluation procedures.

Literature Review

The negative impact of sexual trauma on behaviors is likely due to psychological distress that manifests as various forms of psychopathology, such as posttraumatic stress disorder, depression (Davis et al., 2018), and substance use (Testa & Livingston, 2010). For children and adolescents who have had traumatic sexual experiences, shame and blame are often prevalent as children internalize that the abuse was their fault or something they deserved or wanted (International Society for Traumatic Stress Studies, 2018). As a result, many children never disclose the abuse or they disclose later in life when they are older (Fontes & Plummer, 2010). Thus, while the impact of sexual trauma on children can be severe, professionals implementing sexual health interventions may never know who in a group of children has experienced sexual trauma.

The scripted content in some sexual health interventions includes shame and fear-based content (Fava & Bay-Cheng, 2013) that can trigger a trauma response and subsequently have a negative impact on learning. Condom demonstrations are one example of how curricula may be triggering for youth (e.g., if they have been forced to touch a penis against their will, this may remind them of that traumatic experience). The result may be that youth miss out on the applied learning example of how to appropriately use condoms, thus lessening

their acquisition of safe sex practices. Sexual health interventions may also place blame on youth who have experienced sexual trauma by phrasing all early sexual activity as a destructive choice that is linked to a myriad of negative consequences, including health risk behaviors, illness, and death (Wilson et al., 2012). Perspectives such as these fail to acknowledge that one or more youth in the class may have contracted an STD through sexual violence victimization, an experience that was not their choice.

Despite evidence that fear inhibits learning (Perry, 2006), “fear appeal” is often used in public health interventions to reduce health risk behaviors (e.g., smoking; Fairchild et al., 2018). This type of approach is also used in sexual education curricula. Examples include visual depictions of STIs, sole focus on statistics regarding infection rates, and/or shaming of sexually active youth by associating their behaviors with poor mental health outcomes and depictions of youth whose lives are ruined by their sexual choices (Wilson et al., 2012). While some evidence speaks to the utility of fear appeals in changing behaviors, there is also evidence that supports an association between fear and lowered levels of self-efficacy, thus rendering the fear appeals ineffective (Witte & Allen, 2000). Accordingly, other research suggests that fear appeals incite more fear, stigma, and prejudice, which leads to marginalizing groups and blaming victims (Lederer, 2016). Therefore, when sexual health interventions do not address and account for trauma in their programming, there is great potential for harm and lack of learning among youth who have experienced sexual trauma. While sexual education interventions are not intended to be (nor should they be) trauma specific interventions (i.e., intervention designed to process the impact of and symptoms resulting from trauma; Fallot & Harris, 2008), the experiences of vulnerable youth who have experienced sexual trauma could be (and should be) considered when designing programming (Racine et al., 2020). Without a trauma-informed approach to programming, the tendency is to focus solely on the negative aspects of sexual trauma as opposed to the potential for posttraumatic growth and overall resilience of youth. In addition to a trauma-informed approach, a sex positive framework can highlight the healing aspects of sexual health and potential for sexual experiences and relationships to be growth promoting (Fava & Bay-Cheng, 2013).

Trauma-informed sexual health interventions that balance the need to minimize retraumatization with a strengths-based, skills-oriented approach that bolsters resilience and empowerment through cultivating healthy relationships and positive forms of sexual expression can facilitate a more inclusive and supportive learning environment for all youth, while potentially promoting lasting sexual health benefits. Therefore, it is critical to examine the current state of sexual health interventions and the ways in which they do or do not consider trauma.

Method

In this study, we conducted a scoping review of sexual health interventions for adolescents. The purpose of this study is (a) to present findings related to how trauma is (or is not) addressed in sexual health interventions for adolescents and determine; (b) the prevalence of sexual health interventions for adolescents that address trauma, and (c) the extent to which trauma was addressed in order to provide an accurate depiction of the current state of sexual health interventions.

A scoping literature review is an appropriate methodological approach to address areas of literature where little to no research has been previously conducted (Arksey & O'Malley, 2005). Unlike a systematic review wherein researchers define their questions with an understanding of existing gaps and areas of clarity, a scoping review is a method of mapping areas of literature to identify these gaps in the first place (Armstrong et al., 2011). Accordingly, scoping reviews address broad topics incorporating a variety of methodological designs (Arksey & O'Malley, 2005) and synthesize the literature in a qualitative fashion (Armstrong et al., 2011). Little is known about how and to what extent trauma is addressed in sexual health interventions for adolescents. In accordance with this uncertainty, we conducted a scoping review of published empirical journal articles about sexual health interventions for adolescents to understand the extent to which trauma was included in these interventions. Trauma was defined in congruence with American Psychiatric Association (2013) as a persisting negative emotional and psychological response to an event that one directly experiences, witnesses, or is indirectly exposed to in a repeated fashion. In addition to accidents and natural disasters, these events include all forms of sexual violence and encompass dating, domestic, and intimate partner violence, stalking, online harassment, bullying, and so on.

Search Strategy

This review considered all sexual health intervention studies conducted with adolescents that were published within the last decade (2008–2018). A search of all relevant studies took place during the months of March and April, 2018. The search was conducted using the EBSCOhost platform of a large, research-intensive public university in the following databases: PsychINFO, CINAHL Plus with Full Text, MEDLINE, Education Source, and Psychology and Behavioral Sciences Collection. The search string used was (adolescent OR teen* OR youth) AND ("sex* health" OR "reproduct* health" OR "pregnan* prevent**" OR "sex* education" OR "reproduct* education" OR sex* OR reproduct*) AND (intervention OR program OR "program evaluation" OR course* OR module* OR class* OR curricul*). Qualitative and quantitative studies were included if: they were written in English, conducted in the United States, published in peer-reviewed journals, and contained a description of a sexual health intervention geared

toward youth. Articles of a review nature (e.g., meta-analysis, reviews) were not included. The decision of the research team to exclude non-U.S.-based studies was based on widely varying cultural discrepancies among different nations regarding attitudes toward sexual health and trauma and its influence on the content and approaches used in sexual health interventions. The search yielded an initial pool of 169 articles. After applying our exclusion criteria, there were 38 full-text articles remaining to be reviewed. During this review process, additional articles were identified that did not meet our inclusion criteria. This systematic process resulted in a total of 29 studies for inclusion in the final synthesis (see Tables 1 and 2). A full outline of the search and review process is detailed in Figure 1.

Analytic Procedures

Based on the recommendations of Arksey and O'Malley (2005), we analyzed all 29 articles to determine (a) whether trauma was included at all in the content of an intervention and (b) how trauma was addressed, in terms of breadth, depth, and context. First, a coding sheet was developed to capture and organize data relevant to the research questions, including characteristics of the study, participants, and interventions. Study characteristics included (a) methodological approach, (b) location, and (c) sample size. Participant characteristics were composed of (a) age, (b) biological sex, and (c) race/ethnicity. In addition, intervention characteristics included (a) the name, (b) approach, (c) duration, (d) basic structure, and (e) major content areas covered in each intervention. See Table 1 for study and participant characteristics and Table 2 for intervention characteristics. The first author conducted the full analysis of each article, using the second and fourth authors as a reliability check.

Results

This section contains a narrative synthesis of the study, participant, and intervention characteristics. Additional information on the characteristics of the study and sample is provided in Table 1, while further details regarding intervention characteristics can be found in Table 2. Descriptions of each of the sexual health interventions reviewed, categorized by whether they used an abstinence-oriented or comprehensive approach, can be found in the Supplemental Material supporting this article.

Narrative Synthesis

Study Characteristics

Study methods. All included studies used methodological designs that were of either a qualitative, experimental, quantitative nonexperimental, mixed-methods, or conceptual nature. Studies using random assignment of participants were considered experimental, while those of a quantitative

Table I. Summary of Study and Participant Characteristics.

Authors (year)	Methodology	Location	Sample size	Age	Biological sex	Race/ethnicity ^a or birth origin
Akintobi et al. (2011)	Quantitative, Nonexperimental	Georgia, USA	N = 323	Age range = 12–18 years; mean age = 14.5 years	Male = 44%; female = 55.7%	Hispanic (classified separately as ethnicity) = 5.1%, Black = 88.7%, White = 2.8%, Asian/Pacific Islander = 0.9%, Other = 7.5%
Causey et al. (2012)	Conceptual	California, USA	N = 1,580 (youth)	Age range = younger than 12 to 18 years = 67%	Male = 33%; female	Hispanic ^a = 79%, Black = 3%, White = 6%; Asian/Pacific Islander = 4%, Native American/Alaska Native = 1%, Other (more than 1 race) = 65%
de Anda (2008)	Quantitative, Nonexperimental	California, USA	Two separate samples: N = 419 (Sample 1); 477 (Sample 2)	Age range = 12–20 years (Sample 1); 12–18 years (Sample 2)	Male = 47.5% (Sample 1); 57.0% (Sample 2); Female = 42.6% (Sample 1); 43.0% (Sample 2)	(Sample 1) race/ethnicity not reported, Hispanic = 74.4%; Black = 6.9%; White = 12%
Erikut et al. (2012)	Experimental	Massachusetts, USA	N = 1,223; Intervention = 57.6%, Control = 42.4%	Age range 10.33–15.92 years; mean age = 12.88 years	Male = 45%; female = 55%	Hispanic (categorized as ethnicity, but appeared to be measured together with race in the frequency count) = 35%; Black = 32%; White = 24%;
Escobar-Chaves et al. (2011)	Mixed methods	Puerto Rico, USA	N = 73	Age range = 12–14 years; mean age = 12.66 years	Male = 32.5%; female = 67.5%	Location of birth: Puerto Rico = 84.9%, United States (locations other than Puerto Rico) = 4.1%, Other countries = 6.8%
Fenzl and Andressen (2013)	Quantitative, Nonexperimental	Illinois, USA	N = 24	Age range = 13–18 years	Male = 50%; female = 50%	Hispanic = 100%
Giorgio et al. (2013)	Quantitative, Nonexperimental	United States	N = 32,589	Age range = ≤17 to ≥25 years	Male, n = 3,427; female, n = 28,575	Hispanic, n = 4,881, Black n = 4,429, White, n = 12,119, Other, n = 4,821
Grossman et al. (2013)	Mixed methods	Massachusetts, USA	N = 980 (at baseline; 703 completed intervention; 33 participants in subset used for qualitative purposes)	Mean age = 11.83 years (in 6th grade), 12.77 years (in 7th grade)	Male = 46%; female = 54%	Hispanic = 29%, Black = 30%, White = 32%, Asian/Pacific Islander = 4%, Other (Biracial) = 5%
Grossman et al. (2014)	Experimental	Massachusetts, USA	N = 2,453; Control n = 1,231; Intervention, n = 1,221	Control M = 14 (SD = 0.74); Intervention M = 13.88 (SD = 0.78)	Male = 52% (control), 42% (intervention); female = 48% (control), 58% (intervention)	Hispanic = 37% (Control), 35% (Intervention), Black = 42% (Control), 32% (Intervention), Other (Biracial) = 14% (Control), 14% (Intervention)
Gruchow and Brown (2011)	Experimental	North Carolina, USA	N = 230; Control n = 106; Intervention, n = 124	Years not specified (participants were in grades 7, 8, or 9)	Male = 100%	White = 53.8% (Control), 57.3% (Intervention), Other (non-White) = 46.2%, (Control), 42.7% (Intervention)

(continued)

Table 1. (continued)

Authors (year)	Methodology	Location	Sample size	Age	Biological sex	Race/ethnicity ^a or birth origin
Guilamo-Ramos et al. (2011)	Experimental	New York, USA	N = 2,016 (mother–adolescent dyads)	Mean age = 12.2 years	Male = 49.8%; female = 50.2%	Not provided
Jennings et al. (2014)	Quantitative, Nonexperimental	New Jersey, USA	N = 157	Mean age = 16.24 years	Male = 30%; female = 70%	Black = 32%, White = 39%; Asian/Pacific Islander = 18%; Other = 12%
Koo et al. (2011)	Experimental	Washington, D.C.	N = 928	5th graders: ≤ 11 years (94%), 12 (6%); 6th graders: ≤ 13 (98%)	Male = 46%; female = 54%	Black = 99%; Other = 1%
Lederman et al. (2008)	Experimental	Texas, USA	N = 192 (parent–youth dyads)	Youth only: age range = 11–15 years	Male = 41%; Female = 59%	Hispanic = 36%, Black = 29%, White = 24%; Other (including Asian) = 11%
Lemieux et al. (2008)	Quantitative, nonexperimental	United States	N = 306	Mean age = 16 years	Male = 51%; female = 49%	Hispanic = 43%, Black = 37%, White = 4%; Asian/Pacific Islander = 2%, Native American/Alaska Native = 1%, Other = 13%
Markham et al. (2009)	Quantitative, Nonexperimental	United States	N = 32 (assessed usability); Subsample, n = 20 (assessed clinical feasibility); N = 1,258	Age range = 13–24 years; mean age = 17.8 years	Male = 37.5%; female = 59.8%	Hispanic = 28.1%, Black = 68%, White = 31%
Markham et al. (2012)	Experimental	United States	N = 4,114	Mean age = 12.6 years	Male = 40.2%; female = 59.8%	Hispanic = 48.4%, Black = 39.3%, Other (including White, Asian, and non-Hispanic multiracial youth) = 12.2%
Marques and Ressa (2013)	Conceptual	California, USA	N = 522	Not provided	Not provided	Not provided
Milhausen et al. (2008)	Experimental	Alabama, USA	N = 26	Age range = 14–18 years; mean age = 16 years	Female = 100%	Black = 100%
Morrison-Beedy et al. (2013)	Qualitative	United States	N = 1,374	Age range = 15–19 years; mean age = 16.2 years	Female = 100%	Black = 100%
Peskin et al. (2015)	Experimental	Texas, USA	N = 532	Mean age = 14.3 years	Male = 41%; female = 59%	Hispanic = 73.7%, Black = 17.3%
Pinkleton et al. (2008)	Quantitative, Nonexperimental	Washington, USA	N = 335	Age range = 11–19 years; mean age = 14 years	Male = 47.3%; female = 52.7%	Hispanic = 13%, Black = 8%, White = 72%; Asian/Pacific Islander = 9%, Native American/Alaska Native = 8%; Not provided or not identified = 4%; Other = 11%
Raghupathy et al. (2013)	Experimental	California, USA	N = 335	Age range = 12–19 years; mean age = 15.5 years	Male = 58.9%; female = 42.1%	Hispanic (estimated separately as ethnicity ≈ 80%, Black = 4.7%, White = 9.7%, Asian/Pacific Islander = 6.5%, Native American/ Alaska Native = 22.9%)

(continued)

Table I. (continued)

Authors (year)	Methodology	Location	Sample size	Age	Biological sex	Race/ethnicity ^a or birth origin
Sherr et al. (2013)	Experimental	Florida, USA	N = 973; Control, n = 424; Intervention, n = 549	Age range = 13–17 years	Male = 40.9% (control); 48% (intervention); female = 59.1% (control), 52% (intervention)	Hispanic = 68.4% (control), 72.1% (intervention), Black = 26.8% (control), 28.8% (intervention), Other (included White) = 7.8% (control), 7.1% (intervention)
Sieving et al. (2012)	Experimental	United States	N = 128	Age range = 13–17 years	Female = 100%	Black = 58.6%, White = 44.5%, Asian/Pacific Islander = 6.3%, Native American/Alaska Native = 15.6%, Other = 3.1%
Smith et al. (2011)	Qualitative	United States	N = 1,130	Age range = 1–18 years; mean age = 14.3 years	Male = 51.3%; female Hispanic = 73.7%, Black = 18.7%, White = 1.2%, Other = 3.5%	
Stevens et al. (2013)	Quantitative, Nonexperimental	Arizona, USA	N = 149; Intervention 1, n = 66; Intervention 2, n = 83	Age range = 13–17 years; mean age = 15.7 years	Intervention 1: male = 0%, female = 100% Intervention 2: male = 64%; female = 36%	Intervention 1: Hispanic ^a = 58%, Black = 6%, White = 39%, Asian/Pacific Islander = 2%, Native American/Alaska Native = 5%, Native Hawaiian = 3%, Other (multiracial) = 5%; Intervention 2: Hispanic ^a = 70%, Black = 11%, White = 18%; Asian/ Pacific Islander = 1%, Native American/Alaska Native = 7%, Native Hawaiian = 0%, Other (multiracial) = 1%
Yager and O'Keefe (2012)	Quantitative, Nonexperimental	United States	N = 34	Age range = 13–18 years	Male = 49%; female = 51%	Not provided
Yoost et al. (2014)	Quantitative, Nonexperimental	Kentucky, USA	N = 121	Age range = 11–18 years	Female = 100% Other = 5%	Hispanic = 3%; Black = 65%; White = 27%;

^aStudies that measured Hispanic ethnicity separate from race are noted in parentheses.

Table 2. Summary of Intervention Components.

Authors (year)	Intervention name	Approach used in intervention	Trauma addressed in intervention
Akintobi et al. (2011)	2 Hype Abstinence Club (2 HYPE "A" Club)	Abstinence-oriented	Yes ^a
Causey et al. (2012)	Promoting Alternatives for Teen Health through Artes Teatro (PATH-AT) program	Abstinence-oriented	No
de Anda (2008)	The GIG	Comprehensive	Yes ^a
Erkut et al. (2012)	Get Real: Comprehensive Sex Education That Works	Comprehensive	No
Escobar-Chaves et al. (2011)	It's Your Game: Keep It Real (IYG)	Comprehensive	No
Feutz and Andresen (2013)	Cuidate	Comprehensive	No
Giorgio et al. (2013)	Not provided	Comprehensive	No
Grossman et al. (2013)	Get Real: Comprehensive Sex Education That Works	Comprehensive	No
Grossman et al. (2014)	Get Real: Comprehensive Sex Education That Works	Comprehensive	No
Gruchow and Brown (2011)	Wise Guys Male Responsibility Curriculum	Comprehensive	Yes ^b
Guilamo-Ramos et al. (2011)	Families Talking Together (FTT)	Comprehensive	No
Jennings et al. (2014)	Teen Prevention Education Program (Teen PEP)	Comprehensive	Yes ^b
Koo et al. (2011)	Building Futures for Youth (BFY)	Comprehensive	No
Lederman et al. (2008)	Parent-Adolescent Relationship Education (PARE)	Comprehensive	No
Lemieux et al. (2008)	Not provided	Comprehensive	No
Markham et al. (2009)	+CLICK	Comprehensive	No
Markham et al. (2012)	It's Your Game Keep It Real—Two versions:(1) a RR (risk reduction) program;(2) an RA (risk avoidance) program	RR = Abstinence-plus; RA = Abstinence-only or abstinence-until-marriage	No
Marques and Ressa (2013)	The Sexuality Education Initiative	Comprehensive	Yes ^b
Milhausen et al. (2008)	Not provided	Comprehensive	No
Morrison-Beedy et al. (2013)	The Health Improvement Project for Teens (HIPTeens)	Comprehensive	No
Peskin et al. (2015)	It's Your Game-Tech (IYG-Tech)	Comprehensive	No
Pinkleton et al. (2008)	Take It Seriously: Abstinence and the Media (TISAM)	Abstinence-oriented	No
Raghupathy et al. (2013)	Abstinence and Contraception Education Storehouse (ACES)	Comprehensive	No ^b
Sherr et al. (2013)	Project U-Turn	Comprehensive	No
Sieving et al. (2012)	Prime Time	Comprehensive	No
Smith et al. (2011)	Big Decisions	Comprehensive	No
Stevens et al. (2013)	Two subgroups of interventions, each falling under the scope of the larger Health Education for Youth (HEY) intervention:(1) Las Rosas; (2) Step Forward	Comprehensive	Yes ^c
Yager and O'Keefe (2012)	Teen Sexual Health Information (a business Facebook networking website)	Comprehensive	No
Yoost et al. (2014)	Not provided	Comprehensive	No

Note. STIs = sexually transmitted infections; STDs = sexually transmitted diseases; HIV = human immunodeficiency virus; AIDS = acquired immunodeficiency syndrome.

^aAddressed in outcome measures. ^bIncluded trauma-related topics in the intervention content (content was included in the overall curriculum, but was not implemented as part of the evaluation in Raghupathy et al., 2013). ^cAssessed trauma histories of participants and provided trauma-informed strategies for facilitators.

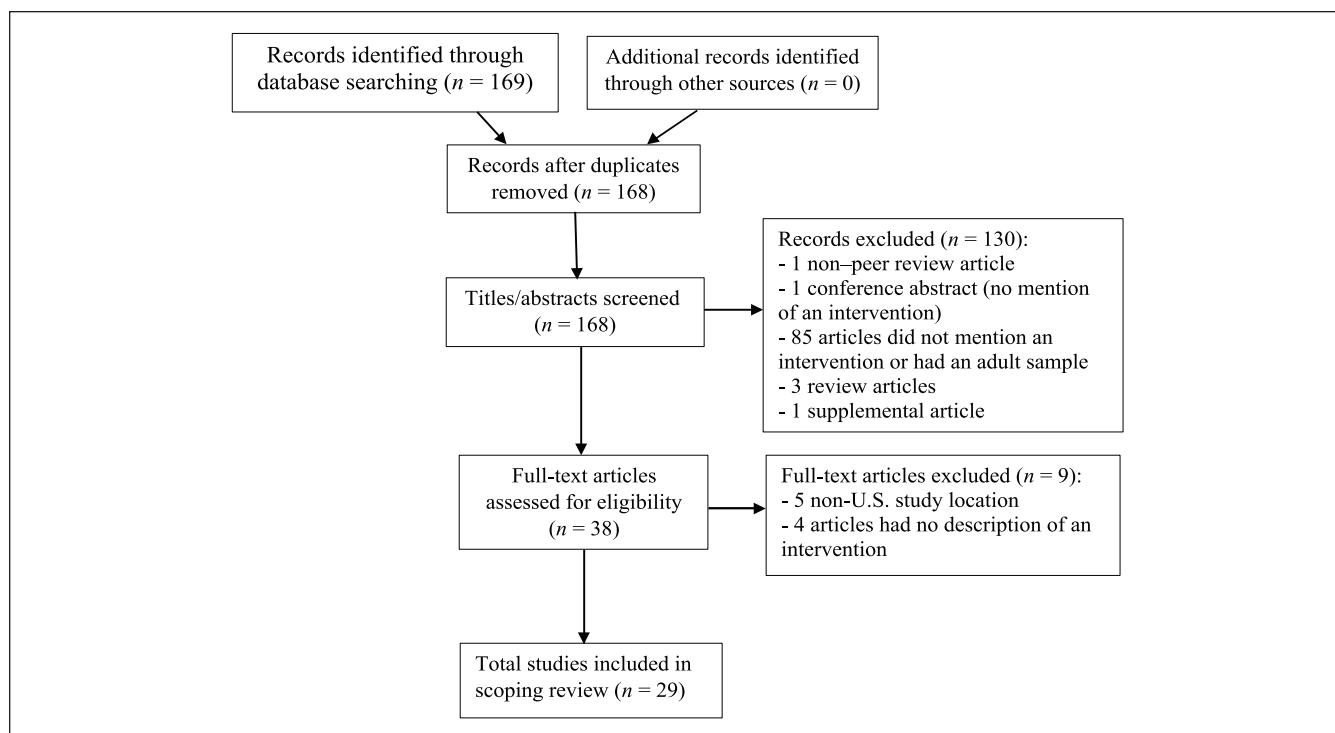


Figure 1. Flow of information from identification to inclusion of studies.

nature that did not use random assignment (including quasi-experimental designs) were classified as quantitative, nonexperimental. Of the 29 articles included in this scoping review, the majority used a quantitative approach, experimental or otherwise. Experimental designs were used in 12 studies, and quantitative, nonexperimental methodology was implemented in 11 studies. Two studies used a qualitative approach, while another two used a mixed-methods design. The remaining two studies were of a conceptual nature.

Study location. The location of each study was categorized by U.S. state or territory. Of the 21 studies providing this information, seven were conducted in the southern United States, six in the western region of the United States, and five in the northeastern United States. One study was conducted in a Midwestern state and another was located in Washington, D.C. The remaining study was conducted in Puerto Rico. All regional information was categorized according to the most recent regional divisions of the U.S. Census Bureau (n.d.).

Sample size. The overall sample size consisting of all youth who were participants across the 29 studies was 54,698. Several studies used parent-child dyads as participants ($n = 7$); only the youth were included in the overall sample count. The study with the largest sample size consisted of 32,589 participants (Giorgio et al., 2013). In contrast, the study with the smallest sample size contained 24 participants (Feutz & Andresen, 2013).

Sample Characteristics

Age. Across the included studies, the youngest participants were 10.33 years old (Erkut et al., 2012) and the oldest were 25 years old (Giorgio et al., 2013). Some studies did not provide a specific age range for participants ($n = 11$).

Biological sex, race, and ethnicity. Of the studies providing information on the biological sex and/or racial ethnic background of participants, the majority were comprised of samples of both male and female participants from a variety of racial/ethnic backgrounds. However, five studies focused on a single sex, while another four were comprised of participants from a single, or nearly single racial/ethnic background. One study reported a sample of male youth only. Four studies were specific to females, and two of these studies were exclusive to Black females. One study reported a sample that was 100% Hispanic, and another study reported a sample that was 99% Black.

Intervention Characteristics. A total of 26 primary interventions were included in the reviewed studies. Interventions were categorized as either comprehensive or abstinence based. The primary criteria used was based on how the authors of each article described their intervention. If that information was not provided within the article, the authors searched on the internet for additional information about how the creators of the intervention classified it. If this additional search failed to yield such information, the authors

agreed to list all interventions with a component on safe sexual practices as comprehensive; programs were categorized as abstinence-only if they explicitly advocated abstinence as the only viable form of safe sexual practice. Some interventions mixed these approaches and are noted as such. Nearly 90% ($n = 22$) of the reviewed studies used a comprehensive approach to sexual education, while four articles described an abstinence-oriented approach for the primary intervention. Four studies used comprehensive and abstinence-based adaptations of the same intervention, *It's Your Game—Keep It Real*. One study compared a comprehensive approach with alternative treatment conditions, including an abstinence-oriented approach, as well as a combination of these two programs.

Interventions Addressing Trauma

Of all 26 interventions reviewed for this study, only 23% ($n = 6$) addressed the topic of trauma (see Table 2). Again, any mention of trauma (e.g., sexual abuse, dating violence, etc.) in intervention modules, curriculum, or outcome measures were used as an indication that this was covered to some extent in the intervention. For example, *The Wise Guys Male Responsibility Curriculum* and *Teen Prevention Education Program (Teen PEP)* included dating violence as part of their intervention content, thus these interventions were included in our review. In addition, *Teen PEP* also covered information related to other trauma-specific topics such as sexual harassment and rape. In one of the first educational sessions on sexuality as part of the *Sexuality Education Initiative* intervention, there is a film to address the topic of masculinity, the cycle of violence, and healthy behaviors in relationships (Marques & Ressa, 2013). Another film used in this intervention addressed the imbalance of power within relationships and issues of sexual consent, coercion, rape, and abuse. Although the Abstinence and Contraception Education Storehouse (*ACES*) curriculum, which contains 40 modules, in the intervention described by Raghupathy et al. (2013) did not address trauma-specific content, it should be noted that one module addresses content relevant to sexual abuse, such as coercion and identifying signs of danger regarding potentially abusive situations.

One intervention seemed to consider the ways in which a history of trauma may affect participation in the intervention. Stevens et al. (2013) stated that the *Health Education for Youth (HEY)* intervention accounts for situations such as a history of abuse (applicable to many of the female participants receiving the *Las Rosas* subintervention) or gang involvement among their participants. *HEY* facilitators are encouraged to meet after each session to review the anonymously submitted questions and conduct necessary research and follow-up on topics such as anonymous disclosures of abuse; facilitators must refrain from reading aloud anonymous questions involving extreme violence.

Other studies addressed trauma in their outcome measures. For example, violence and stress management coping skills were included among the outcome measures in the *2 Hype Abstinence Club* intervention. In addition, an evaluation of the *The GIG* intervention included an item about sexual coercion. Specifically, participants were asked to rate the following question as right (correct) or wrong (incorrect): "don't listen when a woman says 'stop' or 'no' to sex, 'cuz she's just playin with you" (de Anda, 2008, p. 61).

Discussion and Implications for Practice

The purpose of this study was to conduct a scoping review of how trauma is (or is not) addressed within current sexual health interventions designed for adolescents. Our intent was to determine the prevalence of interventions addressing trauma, the extent to which trauma was addressed, and to discuss the implications our findings have for the sexual health of adolescents. Our inclusion criteria for this review were rather generous, with any mentions of an emotional response to a traumatic event, or a traumatic event itself (e.g., sexual abuse, dating violence, etc.) in the intervention modules, curriculum, outcome measures, or acknowledgment of adolescents' own experiences used as an indication that the intervention addressed trauma in some way. Our findings shed light on the dearth of attention given to trauma within sexual health interventions. Of the 26 interventions reviewed, only six (23%) addressed the topic of trauma. Of those interventions that addressed trauma, there were varying degrees of the extent and breadth to which it was covered with varying formats of content delivery.

Trauma-related topics that were covered in the reviewed interventions included: dating violence (Gruchow & Brown, 2011; Jennings et al., 2014), sexual harassment and rape (Jennings et al., 2014; Marques & Ressa, 2013), masculinity, the cycle of violence, healthy behaviors in relationships, sexual consent, abuse, coercion, and power (Marques & Ressa, 2013). As an example, Marques and Ressa (2013) delivered information about trauma (i.e., masculinity, the cycle of violence, healthy behaviors in relationships, sexual consent, coercion, rape, and abuse) via the use of film in their sexuality education initiative. Another study accounted for history of abuse or gang involvement among their participants by allowing participants to anonymously submit questions and disclosures of such events and provided trauma-informed strategies for facilitators (Stevens et al., 2013). Finally, two studies did not specifically describe how their intervention included trauma content; however, trauma was included in the outcome measures (Akintobi et al., 2011; de Anda, 2008).

Overall, the paucity of content related to trauma highlights an important gap in sexual health interventions for adolescents. It is empirically established that childhood adversity and trauma affect the growth and development of adolescents and young adults, including their sexual health

and well-being (International Society for Traumatic Stress Studies, 2018; Trickett et al., 2011). Trauma and childhood maltreatment, including, but not limited to, sexual victimization as a child, is consistently identified as a predictor of negative physical and relational sexual outcomes later in life such as transmission of STIs, high-risk sexual behaviors (e.g., multiple partners, lack of contraceptive use, survival sex), early pregnancy (Davis et al., 2018), and difficulties in building and maintaining positive relationships (Anthonysamy & Zimmer-Gembeck, 2007; Kim & Cicchetti, 2010; Trickett et al., 2011). These physical and relational factors play a critical role in the development of sexual and romantic relationships that are formed throughout adolescence and young adulthood. Additionally, the consequences of a history of traumatic experiences can negatively affect learning (Perry, 2006; Shonkoff et al., 2009), potentially limiting the effectiveness of traditional sexual health interventions. Despite this evidence, sexual health interventions, by and large, omit content related to trauma and trauma-informed components (Fava & Bay-Cheng, 2013).

Furthermore, certain groups of youth are more likely to experience trauma. For example, youth from racial, ethnic, and gender minority groups are more likely than their nonminority peers to experience certain types of trauma including childhood sexual abuse, physical abuse, and community violence (Sales et al., 2016) as are youth living with intellectual and developmental disabilities (Charlton et al., 2004; Goldson, 2002). Yet, despite this documented and increased risk for trauma and the negative outcomes associated with trauma and childhood maltreatment, these marginalized youth are often an afterthought when designing interventions. Indeed, researchers have highlighted this gap in sexual health interventions, for example, as it relates to violence experienced by transgender individuals (Sales et al., 2016) and the desexualization of individuals with intellectual and developmental disabilities (Esmail et al., 2010). Interventions need to be inclusive and deliberate in including content that represents experiences of all youth in a way that is universally accessible, especially those who are more likely to experience trauma and stigmatization.

Applying a trauma-informed framework to comprehensive sexuality education programs could broaden the reach of sexuality health interventions and more fully support all youth, regardless of their previous experiences of trauma and/or maltreatment. Following recommendations by Fava and Bay-Cheng (2013), trauma-informed sexuality education is one that “acknowledges past experiences of abuse, the promise of resilience, and young people’s right to positive sexualities” (p. 1) by building off the trauma-informed principles of safety, choice, collaboration, trustworthiness, and empowerment (Substance Abuse and Mental Health Services Administration, 2014). This approach may help youth with trauma histories place less blame on themselves and feel more able to engage with content related to healthy sexual

and romantic relationships and experiences, despite other marginalizing aspects of their identities. Researchers such as Arbeit (2014) propose a model to guide trauma-informed sexuality education that includes three main dimensions: sexual selfhood, sexual negotiation, and sexual empowerment. This model draws on strengths-based skills and recognizes evidence of positive outcomes related to safe and consensual sexual exploration, but it also leaves room to provide accurate content related to trauma (Arbeit, 2014). These models provide support for programs that target opportunities for positive sexual development for youth. Rather than using fear-based tactics that may prohibit traumatized youth from experiencing benefits of sexual health interventions, a trauma-informed strength-based approach focusing on skill development and resilience can promote a more inclusive learning atmosphere.

Limitations

Limitations of this study should be noted. First, this review excludes any sexual health interventions that are currently being implemented that are not included in a peer-reviewed journal. Second, the purpose of this article was to determine the prevalence of sexual health interventions that address trauma and the extent to which trauma was addressed to provide an accurate depiction of the current sexual health intervention landscape. Thus, this review does not include an analysis on the effectiveness or results of the different interventions available. Future research should further investigate current sexuality health interventions that include trauma-informed components in order to determine their effectiveness and to determine which trauma-informed components are associated with the highest impact in order to advance the evidence-based implementation of trauma-informed sexuality education.

Conclusions

Though there is still much to learn in terms of program evaluation and effectiveness, there is substantial literature about how and why trauma affects adolescent sexual behavior and health and the need for trauma-informed approaches in sexuality education. This article documents the current state of the sexual health interventions for youth that have been published in peer-reviewed journals. There is an existing body of literature that provides direction for how to develop and implement trauma-informed content that is compatible with existing curriculum (Schladale, 2013). Future programs should incorporate a trauma-informed approach in sexuality education for adolescents and focus on content that is comprehensive, positive, and skill building to promote healthy development.

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Supplemental Material

Supplemental material for this article is available online at <https://journals.sagepub.com/home/heb>.

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