

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING
CHILDHOOD, RELIGIOUS VALUES, AND FAMILY
CONVERSATIONS WITH SEX ANXIETY

By

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Abstract: There is a gap in the literature on sex anxiety and an individual's religious emphasis during childhood and values, pertaining to monotheistic religions. Little is known or understood about which factors relate to sex anxiety. The purpose of this study was to determine if a relationship existed between emphasis on religious values during childrearing, current religious values, and caregiver child conversations regarding sex and anxiety surrounding sex acts and practices. It was hypothesized that increased emphasis placed on religious practices during childhood, lower family sex communication, and high religious values would predict high levels of sex anxiety. The findings indicate limited family communications about sex and religious emphasis during childrearing as statistically significant contributors to the variance in sex anxiety. Current religious beliefs did not contribute to the variance in sex anxiety.

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Chapter I

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD, RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

There is limited literature on what impact the negative connotation of sex within many religious communities, specifically monotheistic religions, has on the individual (Bruess & Schroeder, 2014; Garcia & Kruger, 2010). One potential implication developed from the negative emphasis placed on sex within religious communities is sex anxiety (Garcia & Kruger, 2010). Sex anxiety, sometimes referred to as erotophobia, is defined as fear or anxiety with regards to sex, specific sex acts, or sexual practices (Fallis, Gordon, & Purdon, 2011). The definition can vary greatly depending on how the anxiety manifests in relation to sex, i.e. physical, avoidance, or performance (Barlow, 1986). Within the literature, the construct of sex anxiety is often defined in physiological terms and applications (Hertlein, Weeks, & Gambescia, 2009; Kunkel, 1975; Reich, Higgins, & Raphael, 1982; Robinson, 2013). These operational definitions focus on physiological symptoms or sexual dysfunctions such as vaginismus and erectile dysfunction but fail to address the origin of the anxiety (Hertlein, Weeks, & Gambescia, 2009). Sex anxiety, for the purpose of this study, is defined as general anxiety with the topic, discussion, presentation, and expression of sex and sexuality (Fallis, Gordon, & Purdon, 2011).

With regard to sexual dysfunctions, often times the intervention or therapeutic techniques are reactive rather than preventative (Hertlein, Weeks, & Gambescia, 2009). In the case of individuals experiencing vaginismus or erectile dysfunction on their wedding night, the focus of treatment is often on current symptomology and addressing the symptom rather than the cause

(Hertlein, Weeks, & Gambescia, 2009). Some women develop anxiety related to sex, specifically vaginismus, as a result of past trauma, negative sexual attitudes, and a lack of sex education (Hertlein, Weeks, & Gambescia, 2009). Individuals within religious households, where sex may be considered sinful and rarely, if ever, discussed, demonstrate increased levels of anxiety when first engaging in sexual intercourse (Sands, 2000).

Early sexual interaction with limited knowledge is a concern as it is related to increased risk of unintended pregnancies and sexually transmitted infections (Rosenthal, Smith, & De Visser, 1999). Rosenthal, Smith & De Visser (1995) indicated the desire to transition into adulthood before peers is a powerful incentive for youth to engage in sexual activity earlier. The importance of social networks is illustrated in the development of shame, guilt, and anxiety when engaging in sexual intercourse for the first time (Sprecher, Barbee, & Schwartz, 1995). In one study, women were more likely than men to experience shame; however, both men and women reported increased anxiety with sexual interactions when the relationship was meaningful and not just a casual fling (Sprecher, Barbee, & Schwartz, 1995).

As family communication about sex is negatively correlated with sex anxiety, preventative methods could be implemented to decrease anxiety. Preventative methods are invaluable to children who are adversely utilizing alternative methods of sexual health education such as pornography and misinformed blogs or online postings (Flood, 2009). Access and use of pornography as an educational tool is concerning because children and young adults may not be properly educated on the topic of sex and sexual health (Flood, 2009). The concern lies in the availability of explicit material and the average age of first consumption as “pornography is a poor, and indeed dangerous, sex educator” (Flood, 2009 p. 384).

With current trends in technology, researchers find many adolescents are regularly viewing pornographic video clips or films (Weber, Quiring, & Daschmann, 2012). Some estimates suggest up to 90% or more youth between the ages of 12 and 18 have access to the internet (Ybarra & Mitchell, 2005). These technological advances have resulted in a steady increase in the percent of individuals consuming pornography (Wright, Bae, & Funk, 2013). The majority (87%) of youth in a study conducted by Ybarra & Mitchell (2005) reported being 14 years or older when first viewing pornography. Throughout the literature, exposure to pornography prior to 13 years of age was uncommon (Sabina, Wolak, & Finkelhor, 2008; Flood, 2009).

This study applied the model of Information-Motivation-Behavioral Skills (IMBS) to demonstrate the application of the constructs (Fisher & Fisher, 1998). According to the model, the information or lack of information received about sexual and reproductive health information directly influences all other aspects (motivation, skills, and behavior) of sex and reproduction (Fisher & Fisher, 1998). The IMBS model indicates factors which attribute to sexual and reproductive health behaviors (see figure 3 Appendix K). Sexual health information and motivation directly impact one another as do sex health behavior skills and ultimately sexual and reproductive health behavior (Fisher & Fisher, 1998). Sexual information can be provided or sought out during development or childrearing from children's social networks.

Potential Determinants of Sex Anxiety

Religious Emphasis During Childrearing

From a young age children model and mimic adults, peers, family, etc. in an effort to communicate and learn about the world around them (Mahn, 2000). The IMBS model begins with sex health information and sex health motivation (Fisher & Fisher, 1998). Religious

emphasis during the pivotal developmental years for children could influence the interaction between the information received and the motivation for sexual and reproductive health. Young children have higher levels of neuroplasticity, brain formation, and synaptic connections, which allow for increased growth in learning (Worthman, 2010). This construct of increased growth in learning is important when factoring in cultural components such as family systems.

Within an individual's life there are many systems, such as family, which influence the person, both directly and indirectly (Bronfenbrenner, 1999). Learning happens within the social context where individuals adapt and communicate with the environment and others within the system (Mahn, 2000). Bronfenbrenner's ecological model demonstrates the levels of impact and interaction individuals have with the world and systems (Bronfenbrenner, 1999). Each of these systems directly and indirectly impact the individual (Bronfenbrenner, 1999). Sex education and knowledge are valuable and imperative aspects of the human component (Buruess & Schroeder, 2014; Luker, 2006; Sands, 2000). Human development, from an ecological lens, emphasizes the individual's perspective of the environment, the surrounding environment, and the interaction between the individual and the environment (Mahn, 2000). It is this interaction which can ultimately promote health or lead to health disparity (Reifsnider, Gallagher, & Forgiione, 2005).

Family Sex Communication

One major aspect of the individual's environment which may play a role in learning about sex is communication within the family system. *Family sex communication* can be described as the willingness of families to have open lines of communication about sex and sex related topics (Galvin, Braithwaite, & Bylund, 2015). This openness, by the parents or caregivers, enables children to utilize the family unit as a primary source of sexual learning (Warren & Neer, 1986). The communication exchange between parents and their children

directly relates to how likely that child is to share information regarding sex with their own children (Warren & Neer, 1986). Not only is there an increased chance of future generations receiving information, but the openness in communication on such a subject will allow for increased interactions and positive experiences with those interactions (Warren & Neer, 1986). Refusal and failure to share sexual health and educational information leads to ignorance and sexual health disparities (Garcia, Reiber, Massey, & Merriwether, 2012). With an increased understanding of sexual health and associated topics, children could potentially exhibit fewer sexual disparities and greater sexual health (Warren & Neer, 1986).

In researching family sex communication, Warren and Neer (1986) found that families rarely, if ever, discuss sex. In a more recent study, Warren and Warren (2014) found children from families who did practice open sex communication were more willing and open to discuss concerns and health practices with sexual partners. Discussions about sex within families ultimately led to more dialogue and questions between children and parents (Warren & Warren, 2014). Contrary to popular belief, Warren and Neer (1986) concluded that children from families who openly discussed sex in the home did not demonstrate an attitude of sexual license, or promiscuous sexual behaviors in later years. Increased communications about sex within families demonstrates information access in the IMBS model which leads to sexual health skills and sexual health behaviors (Fisher & Fisher, 1998).

One major deterrent for parents to communicate with their children could be their limited knowledge base of sex information to share (Moran, 2000). In addition to inadequate information, parents often emphasize preventing sexually transmitted infections (STI) or avoiding pregnancy, rather than teaching overall sexual health (Bruess & Schroeder, 2014). Parents often believe that children are too young to discuss sex and should be shielded from adult

conversations (Moran, 2000). On the contrary, Robinson (2013) found that conversations between families with young children have many benefits for both the adults and the children. Children can easily become frustrated when they are interested in information they are unable or not allowed to access (Flood, 2009). Increased communications within families not only alleviates this frustration but also increases sexual knowledge and opens conversations for future topics within the child's social networks (Robinson, 2013).

Religious Values

Religion is a large component of many people's social networks where learning and growth occur (Worthman, 2010). Religion can have both positive and negative impacts on the individual (Eshun & Guering, 2009). Throughout the literature and media there are extreme examples of both positive and negative influences with religion in regard to sex (Luker, 2006; Moran, 2000; Sands, 2000). Religious groups and churches are often stereotyped as having a stigma and negativity toward sex (Eshun & Gurung, 2009). Within religious teachings of sex and sex health there is often an increased emphasis placed on values, not facts (Luker, 2006). Although there is variation between and within religious groups, some strategies utilized have very negative outcomes with regard to sex and sex health (Luker, 2006; Moran, 2000). Some negative outcomes include dangerous sex practices and misinformation leading to teenage pregnancy and injury (Luker, 2006). Often times, religious groups use scare tactics when discussing sex with children and "abstinence only" is preached (Moran, 2000). Members of many "abstinence only" religious sects are found to have higher levels of teen pregnancy and lower sexual health practices (Strayhorn & Strayhorn, 2009). Sexual health practices are safe sex, consent, and increased positive sexual behaviors (urinating after intercourse, hygiene, etc.).

Within the IMBS model the construct of religious values would inform sexual health motivation (Fisher & Fisher, 1998).

One major concern is increased mental health disorders within religious populations (Eshun & Gurung, 2009). Individuals within religious communities who have concerns with sex, sex health, and sex identity often delay seeking mental health services (Eshun & Gurung, 2009). Delay in seeking mental health services for sex related health concerns in religious communities is a concern for counseling psychologists and other helping professionals (Eshun & Gurung, 2009; Morrow, Worthington, McCullough, 1993). There are also many positive aspects of religion with regard to sex and sexual health practices (Moran, 2000; Sands, 2000). Churches are large support networks for the individuals they serve, therefore an integration of sex and sex health within the church could be greatly beneficial (Sands, 2000). Cultural aspects, such as religion, can serve as mediators and coping mechanisms for stress and anxiety which can easily be applied to sex (Eshun & Gurung, 2009). Past studies have produced ambiguous and varying results when investigating religious values and sex health or sex related concerns (Eshun & Gurung, 2009; Moran, 2000). There are variations within religion as some sects are open and inclusive of sex health practices while others remain unwilling to discuss sex health related concerns (Sands, 2000). Some researchers suggest that all religious entities are conservative and create anxiety about sex and sexuality (Sands, 2000). Despite mixed findings of sexual health within religious sects, individuals involved in religious networks demonstrate lower levels of general anxiety and depression (Eshun & Gurung, 2009).

Purpose of the Study

This study aimed to determine whether factors such as religious values, religious emphasis during childhood, and family communication were related to increased sex anxiety. For

this study, the focus was not to assume all religious groups are similar but rather to focus on the religious emphasis placed on the participant during childhood, religious values, and family communication on sex.

Research Question / Hypothesis

This study aimed to explore the relationship between religious emphasis during childhood, religious values, family communication about sex, and sex anxiety. The research questions and hypotheses were:

1. Do religious values, religious emphasis during childhood, and family communications about sex predict levels of sex anxiety? How?
2. Does family communication about sex predict levels of sex anxiety to a greater extent than religious values and religious emphasis during childhood do?

Hypothesis 1: Religious values, religious emphasis during childhood, and family communications about sex will predict levels of sex anxiety. Specifically, higher levels of religious emphasis during childhood, higher levels of religious values, and lower levels of family communication will predict higher levels of sex anxiety.

Hypothesis 2: Family communication will be the strongest predictor variable of sex anxiety (see figure 4 Appendix G).

Chapter II

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD, RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

Extended Review of the Literature

The Information-Motivation-Behavioral Skills model (IMB model) was utilized in this study to illustrate the process of information gathering within the environment, which facilitates sex anxiety (Fisher & Fisher, 1998). Developed to demonstrate a simple and generalizable method of determining change within patients, the IMB model is commonly used within the health profession (see figure 3 Appendix I). There are four major components to the IMB model (Fisher & Fisher, 1998). The first component is information, which refers to the basic knowledge and understanding the person has on the particular behavior. Motivation is the other beginning component of the model. Motivation refers to personal attitudes and beliefs on the behavior. Within the context of motivation, the norms of how to behave are found (Fisher & Fisher, 1998). Information and motivation influence one another as well as the next step in the model, which is skills. Tools and access to social support and self-regulation strategies are within the skills step of the model. The final aspect of the IMB model is behavioral change or behavior occurrence (Fisher & Fisher, 1998).

The purpose of this study was to further expand on the model and gain a better conceptualization of what factors and influences contribute to the information and motivation stages of the model (see figure 5 Appendix I). To guide the process of determining variables related to information and motivation it is helpful to rely on previously established theoretical

constructs. As the environment and interactions with others were the main foci of this study, the developmental models of Bronfenbrenner and Vygotsky can be applied to the IMB model and the specific components within the model (Bronfenbrenner, 1999; Fisher & Fisher, 1998).

Within an individual's life there are many systems which influence the person, both directly and indirectly (Bronfenbrenner, 1999). Learning happens within the social context where the person adapts and communicates with their environment and others within their system (Bronfenbrenner, 1999; Fisher & Fisher, 1998). Bronfenbrenner's ecological model demonstrates the levels of impact and interaction one has with the world and systems around them (Bronfenbrenner, 1999). Each of these systems directly and indirectly impact the individual, allowing researchers to investigate the interactions between the individual and their environment. Bronfenbrenner's ecological model demonstrates the levels of impact and interaction one has with the world and systems around them (Bronfenbrenner, 1999). Within Bronfenbrenner's model there are five systems. These systems are as follows; Microsystem, Mesosystem, Exosystem, Macrosystem, and Chronosystem (see figure 1 Appendix I). (Bronfenbrenner, 1994).

The Microsystem includes constructs which immediately interact with the individual, such as family, religious institutions, school, work, peers, etc. (Bronfenbrenner, 1999). The second system is the Mesosystem where interactions between individual's immediate setting and larger social setting take place (Bronfenbrenner, 1999). The Exosystem contains the connections between individual's immediate context and larger social setting in which they do not hold an active role or position (Bronfenbrenner, 1999). The culture in which the person lives is described as the Macrosystem (Bronfenbrenner, 1999). Finally, the Chronosystem consists of environmental events and lifelong transitions. Each of these system's specific components depend on the individual within the center of the ecological system (Bronfenbrenner, 1999).

Each of the systems directly and indirectly impact the individual allowing for researchers to investigate the interactions between the individual and their environment (Bronfenbrenner, 1999).

In addition to Bronfenbrenner's ecological model, the Sociocultural Education Theory by Vygotsky plays an integral role in the analysis of sex anxiety among individuals (Kozulin, 2003). The environment in which children live facilitates external and internal motivations to participate in behaviors they may or may not wholly agree with (Caffray & Schneider, 2000). Vygotsky emphasized children learn from their environment with cues, symbols, words, etc. which they internalize to create meaning and apply to the world around them (Mahn, 1999). The process of developing anxiety or erotophobia (fear of sex) does not solely take place within the environment, as an internal process must also occur (see figure 2 Appendix I) (Fisher & Fisher, 1998). Although Vygotsky's theory is often utilized within the classroom, the constructs of interpsychological (interaction with stimuli around) and intrapsychological (internal process of information received) can be applied to the process of children learning about sex and the social cues associated regarding the topic (Fisher & Fisher, 1998).

There are currently no applications of Vygotsky's sociocultural theory to sex, sex health, or mental health within the literature. This theory is commonly applied within the classroom and functions as a tool to interpret the way children acquire information within their learning environment (Kozulin, 2003). As this model addresses the learning process of children from the environment it can be applied to learning social cues and sex health information.

The specific impact of the environment on the individual's mental health is a complex factor to both identify and measure (Eshun & Gurung, 2009). Levine and Gaw coined the term

“Culture-bound Syndrome” in 1995 to indicate a symptomatology which directly relates to the culture of the individual (Smart & Smart, 1997). The application of this phenomenon is under researched and often produces conflicting results as the construct of culture can vary from one individual to another within the same environment (Smart & Smart, 1997). Due to so many extraneous and internal variables this construct remains ambiguous creating further difficulty in assessing for mental health within cultural contexts (Eshun & Gurung, 2009).

Human development, from an ecological lens, emphasizes the individual’s perspective of the environment, the surrounding environment, and the interaction between the individual and the environment (Reifsnider, Gallagher, & Forgione, 2005). It is this interaction which can ultimately promote health or lead to health disparity (Reifsnider, Gallagher, & Forgione, 2005). Sex education and knowledge are valuable and imperative aspects of the human component (Buruess & Schroeder, 2014; Luker, 2006; Sands, 2000). If society wants to diminish anxiety, sexual dysfunctions related to anxiety, misinformation, and lack of education, it will seek to improve the system which both directly and indirectly impacts the person (Buruess & Schroeder, 2014; Luker, 2006; Moran, 2000; Sands, 2000).

Researchers have found a positive correlation between children’s developmental thinking and their understanding of a particular construct (Myers-Walls & Lewsader, 2015). Snell, Fisher, and Walters (1993) identified three factors which are associated with sexual anxiety: tension, discomfort, and anxiety related towards sex life. Each of these factors are influenced by the individual’s environment (Snell, Fisher, and Walters, 1993). Impacts of these factors create both physiological and psychological concerns (Belsky, Houts & Fearon, 2010). Insecure attachments in infancy, with family, have been correlated with earlier pubertal development and increased

anxiety (Belsky, Houts & Fearon, 2010). Sex anxiety demonstrates psychological concerns with performance as anxiety relates directly with the amygdala, potentially inhibiting performance and creating a cyclical chain of events (Anand, & Shekhar, 2003). Negative correlations with sex anxiety and reported sexual pleasure as well as, an inability to behave sexually have been reported as a result of anxiety (Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006).

Sexual Anxiety

The construct of sex anxiety is operationally defined using the Sexual Anxiety Scale (SAS) (Fallis, Gordon, & Purdon, 2011). The Sexual Anxiety Scale measures negative or positive affect to sexual stimuli. The SAS has a Cronbach's alpha of 0.96 and strong test retest reliability ($r=0.87$, $p<0.01$) (Fallis, Gordon, & Purdon, 2011). The SAS is 56-items which includes statements such as "talking with my friends about my sex life" and "telling my partner what pleases me and does not please me sexually". Responses for items are measured on a continuum (0 extremely pleasurable – 50 neutral – 100 extremely discomforting) (Fallis, Gordon, & Purdon, 2011). Previous research indicates correlations between sexual anxiety and measures of mood and personality, were statistically significant in the following areas: anxiety ($r=.16$), extraversion ($r=-.34$), and intelligence ($r=-.26$) (Fallis, Gordon, & Purdon, 2011). Calculations from three individual factors: Solitary and impersonal sexual expression, exposure to information, and sexual communication, can be reported as an overall score or can be reported as individual factors. Higher scores indicate greater erotophobia, sex anxiety ($M=1946.5$, $SD=674$).

Erotophobia is a learned disposition which results from an individual's socialization (Fisher, White, Byrne, & Kelley, 1988). Erotophobia appears to be constant as personality type when exposed to attitudes of liberal or conservative sexual behaviors (Rye, Serafini, &

Bramberger, 2015). Consequences of erotophobia lead to avoidance in sexual situations (Fisher, White, Byrne, & Kelley, 1988). Explicit levels of guilt are present when moral evaluation is present (Lanciano, Soleti, Guglielmi, Mangiulli, & Curci, 2016). Erotophobia is correlated with sexual problems or sexual concerns (Bradshaw & Slade, 2005). Anxiety can have various effects on sexual arousal and sexual performance (Kempeneers, Pallincourt, & Blairy, 2009). Anxiety can trigger erotic stimulation, also known as a priming effect, which can intensify sexual encounters (Kempeneers, Pallincourt, & Blairy, 2009). On the contrary, anxiety can have a debilitating effect causing the individual to freeze or be unable to perform (Kempeneers, Pallincourt, & Blairy, 2009). Increased exposure to sex and sex related constructs can decrease anxiety and anxiety related concerns to sex (Wright & Cullen, 2001).

There is limited literature on what impact the negative connotation of sex within the religious communities has on the individual however, one potential implication resulting from such religious contempt is sexual anxiety (Hawkes & Egan, 2008). Within the nascent literature the construct of sex anxiety is often defined in physiological terms and applications (Robinson, 2013; Hertlein, Weeks, & Gambescia, 2009; Reich, Higgins, & Raphael, 1982; Kunkel, 1975). These operational definitions focus on physiological symptoms such as vaginismus and erectile dysfunction but they fail to address the origin of the anxiety (Hertlein, Weeks, & Gambescia, 2009). Previous research has identified three factors which are associated with sexual anxiety: tension, discomfort, and anxiety related towards sex life (Snell, Fisher, and Walters, 1993). There are many different psychological factors associated with sexual anxiety.

Other potential contributors to sex anxiety are physical abnormalities, one of which is mechanical tension (Reich, 1982). Sexual anxiety has been shown to have a negative correlation with reported sexual pleasure (Birnbaum, Reis, Mikulincer, Gillath, & Orpaz, 2006). One's

feelings and underlying beliefs towards sexual activity can manifest in childhood as these assumptions about sexuality are solidified through both external and internal processes (Rostosky, Dekhtyar, Cupp, and Andermann, 2008). With this in mind, Rostosky, Dekhtyar, Cupp, and Andermann (2008) found adolescent males reported higher levels of sexual anxiety than their female counterparts. Negative affect and negative exposure to sex directly results in development of negative emotions (Kappes & Schikowski, 2013). This pairing of negative emotions and sex can be a contra indicator to mental health and appropriate sexual practices (Hutchinson, 2012; Idler, Musick, Ellison, & George, 2003). When factoring in increased mental health concerns, it is important to note that women are at an increased risk when compared to men for mental health issues (Fredrickson & Roberts, 1997). Within religious circles other mental health concerns, such as drug use and abuse, are ignored or not talked about (Kendler & Gardner, 1997). These concerns are often overlooked and/or not addressed to protect moral standings (Jinkerson, 2016).

Family Sex Communication

Another aspect of the individual's environment which may play a role in learning and processing about sex is communication within the family system. Family sex communication can be described as the willingness of families to have open lines of communication about sex and sex related topics. This openness by the parents will enable their children to utilize the family unit as a "primary source of sexual learning" (Warren & Neer, 1986). The communication exchange between parents and their children directly relates to how likely that child is to share information regarding sex with their own children. Not only is there an increased chance of future generations receiving information, but the openness in communication on such a subject will allow for increased interactions and a positive experience when such interfaces occur

(Warren & Neer, 1986). Refusal and failure to share sexual health and educational information has previously been demonstrated to lead to ignorance and sexual health disparities (Garcia, Reiber, Massey, & Merriwether, 2012). Studies have found a positive correlation between children's developmental thinking and their understanding of a particular construct (Myers-Walls & Lewsader, 2015). Therefore, increased understanding of sexual health and associated topics would lead to less sexual disparities and greater sexual health.

Communication within the family structure is beneficial and imperative for the system, the family, and the individual to function appropriately (Galvin, Braithwaite, & Bylund, 2015). With this in mind, it is difficult to facilitate conversations within the family of more religious families located within the "Bible Belt". The "Bible Belt" consists of various southern states where there is an increase in religious affiliation (Brunn, Webster & Archer, 2011; Garcia & Kruger, 2010). In an article by Brunn, Webster, & Archer (2011), the geography of the "Bible Belt" was examined using a longitudinal study (1971-2000). Over the course of 30 years, geographical locations within the United States which consisted of increased religious practices (i.e. "The Bible Belt") remained consistent and had few changes. One such change, was the location of the "buckle", or the most densely populated area within the belt. Over the years, this location has slowly moved from the East to the West (Brunn, Webster & Archer, 2011).

In researching family sex communication, Warren and Neer found that families rarely, if ever, discuss sex (1986). In addition, they found when families communicate, children were more willing and open to discuss concerns and health practices with sexual partners (Warren & Warren, 2014). Discussions within families about sex lead to more dialogue and questions between children and parents. Warren and Neer (1986) further concluded that children from

families who openly and freely discussed sex in the home did not demonstrate an attitude of sexual license.

One major deterrent for parents to communicate with their children could be their limited knowledge base of sex information to share (Moran, 2000). In addition to inadequate information, there is often an emphasis placed on preventing sexually transmitted infections (STI) or avoiding pregnancy, rather than teaching overall sexual health. Parents may not have information to share with their child as they too were not educated in schools of other venues about sex health topics. Many Educational systems are not required to teach sex education or preventative measures for STIs therefore the families may have difficulty accessing the information (SIECUS, 2014). Parents often report children are too young and should be shielded from adult conversations. Other accounts indicate conversations between families with young children to have many benefits for both the adults and the children (Robinson, 2013). Children can easily become frustrated when they are interested in information they are unable or not allowed to access. Increased communications between families not only alleviated this frustration but also increased sexual knowledge and opened conversation for future topics within their social networks (Robinson, 2013). Another possible variable which could have a large influence on the constructs is peer interaction and peer conversations about sex (Daugherty & Burger, 1984). Future research could include peer interaction and peer conversation as a potential contributing factor to sex anxiety.

It is possible that rurality could play a large part in sociocultural norms and the degree of a family's willingness to openly discuss sex and associated topics. Information collected from rural populations could inform a need for interventions within the context of sex anxiety and family communication on sex. Rural populations are often underserved and this population is

underrepresented in the area of sexual health research (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006). Additional studies could include the construct of rurality to determine potential relationships with religious emphasis during childhood and sex anxiety informing future research directives.

Religious Emphasis During Childhood

The primary goal and focus of sex and religion appears to be the desire to maintain religious freedom, family, and family values (Sands, 2000). Although there is variation between and within religious groups, some strategies utilized have very negative outcomes with regard to sex and sex health (Luker, 2006; Moran, 2000) Often times, scare tactics are used when discussing sex with children and abstinence only is preached (Moran, 2000). Locations where abstinence only is the focus tend to have a higher level of teen pregnancy (Strayhorn & Strayhorn, 2009). Within religious teachings of sex and sex health there is often an increased emphasis placed on values not facts (Luker, 2006). The Religious Emphasis Scale will be utilized to measure religious practices and importance placed on the participant during child rearing. The Religious Emphasis Scale (RES) inter-item correlation reliability for the 10-item measure was .55 (Allport & Ross, 1967). The RES had a Cronbach's alpha of .92 and .58 for convergent validity when correlated with Allport and Ross' (1967) Intrinsic Religious Orientation Scale (Altemeyer, 1988).

A large focus on "appropriate" gender stereotypes can further complicate anxiety related to sex (Csinos, 2010). The focus on what is right and wrong during a child's upbringing can have an impact on the child's development (Mahn, 2000). The incorporation of sex health and sex education during a child's developmental upbringing is essential to the development of positive

sexual health information, skills, and behaviors (Buruess & Schroeder, 2014; Luker, 2006; Fisher & Fisher, 1998). The family is the main resource for children when acquiring knowledge and information (Mahn, 2000). During the child's learning years, it is the family unit which provides or hinders access to the information.

Access to sex health information can have multiple components in addition to family communication. One construct which can inhibit or facilitate access is rurality. "It is difficult to quantify rural health problems and make informed policy decisions without a clear definition of what and where "rural" areas are" (Hewitt, 1989 p. 2). Operational definitions for rurality vary greatly depending on the application of "rurality". Some definitions include population density, access to health care, distance from urban locations, etc. Within rural religious communities access to sex health information could be more difficult, which can further compound sex anxiety (Eshun & Gurung,-2009).

Rural populations with limited access to resources and services are a vulnerable group. With vulnerable populations, there is an increased focus on reducing disparities and increasing preventative rather than reactive methods (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006). Kilbourne et al. (2006) illustrated the increased health care disparities for at risk populations, which included rural individuals. These at-risk populations are less likely to seek outside information and therefore rely on their immediate environment for resources (Spleen, Lengerich, Camacho, & Vanderpool, 2014). The idea of not seeking information outside of your surrounding area is further confounded within religious communities. This will limit their sex health information which can further compound sex anxiety (Eshun & Gurung, 2009). Rurality could play a large part in sociocultural norms and the degree of family's willingness to openly discuss sex and associated topics. Rural populations are often underserved and this population is

underrepresented in the area of sexual health research (Spleen, Lengerich, Camacho, & Vanderpool, 2014). Operational definitions for rurality are wide ranging and evolving as society becomes more connected (Hewitt, 1989). Future research on sex anxiety and the contributing constructs should seek to address this variable in more depth.

Religious Values

The Religious Commitment Inventory -10 (RCI-10) was used to assess current religious values (Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O'Connor, 2003). The RCI consists of 10 items scored on a Likert type scale to best describe how true the statement is of participants (1 not at all true of me, 2 somewhat true of me, 3 moderately true of me, 4 mostly true of me, 5 totally true of me). Examples of questions include: "I spend time trying to grow in understanding my faith" and "Religious beliefs lie behind my whole approach to life." Cronbach's alpha for the RCI-10 internal consistency is .93 and test-retest .87. The total score was used for the purpose of this study. Higher scores indicate higher levels of religious values. The RCI has been published in counseling journals and is utilized in counseling efforts to identify the importance of religion on individuals (Wade & Worthington, 2006).

Current religious practices were assessed in the demographic section of the survey as well as the use of the DUREL (Koenig, Patterson, & Meador, 1997). The DUREL is a five-item measure which measured reliability and validity using only three of the five items on the index. Reliability indicated a Cronbach's alpha of .75 and validity when correlated with Hoge's 10 item scale was .85 (Koenig, Patterson, & Meador, 1997).

Religion, for some individuals, can be a large component of their social networks where learning and growth occur (Moran, 2000; Daugherty & Burger, 1984). Religious practices vary significantly with regard to attendance and involvement within religious communities which may include frequent gatherings, specific rituals, and predetermined strategies for stressful situations (Moran, 2000). As some persons greatly value religion within their environments, they can be inhibited or empowered by the community's values and beliefs (Moran, 2000). It is often generalized and assumed that religious groups and churches have a stigma and negativity toward sex (Eshun & Gurung, 2009).

Negative stigmas of sex within one's religious entity can lead to negative impacts on that individual's perception of sexual behavior (Moran, 2000). In cases where a religious group demonstrates positive feelings and acceptance toward sexual health the individual can become empowered to acquire information and further share with others information about sexual health (Eshun & Gurung, 2009; Moran, 2000). Within the helping profession there are concerns present when focusing on sex and religion (Eshun & Gurung, 2009). One major concern is increased mental health disorders in marginalized populations (Eshun & Gurung, 2009). Individuals within the church who have concerns with sex, sex health, and sex identity often delay seeking mental health services (Eshun & Gurung, 2009; Ryan, Rigby, & King, 1993).

The debate of moral standing and sex will remain a source of contention for many religious entities and persons (Irvine, 2002). Irvine stated that in order to move forward it is essential to acknowledge that emotions are central to the politics of sex education (2002). The continued battle between liberal and conservative individuals results in casualties consisting of children, teens, and young adults (Sands, 2000). The lack of information directly impacts young

adults within conservative locations as sexual norms practices include abstinence only and younger marriage (Garcia & Kruger, 2010).

On the contrary, there are many positive aspects of religion and sex within the literature (Moran, 2000; Sands, 2000). Churches are large support networks for the individuals they serve, therefore an integration of sex and sex health within the church could be greatly beneficial (Sands, 2000). Cultural aspects, such as religion, can serve as mediators for stress and anxiety which can easily be applied to sex (Eshun & Gurung, 2009). In some areas churches provide curriculum and education for families to incorporate on sex health practices and information (Puffer, Green, Sikkema, Broerman, Ogwang-Odhiambo, & Pian, 2016). Religious commitment related to sex health and sex in past studies has produced ambiguous results (Eshun & Gurung, 2009; Moran, 2000). Despite mixed findings it is clearly indicated that individuals involved in religious networks demonstrated lower levels of general anxiety and depression (Eshun & Gurung, 2009).

Summary

Information seeking in alternative, often deemed less appropriate, avenues occurs when an individual has limited knowledge in their environment. Access and use of pornography as an educator is a concern which may present itself in the instance that children and young adults are not properly educated on the topic of sex and sexual health (Flood, 2009; Sands 2000). This study and its findings are important as they can help to implement preventative methods for sex education so that children are not utilizing alternative methods. By determining a potential predictive relationship, this study will assist in the informative process of both research and clinical practices. Examples of potential application include but are not limited to psychoeducation (sex education), future research directives (sexual health in rural populations, peer interaction), and increased interventions for populations studied (sexual health trainings, increased interventions in practice).

Chapter III

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD, RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

Methodology

Participants in this study included undergraduate and graduate college students at Oklahoma State University currently enrolled in a course which provided research participation as an option within the course. Due to the explorative nature of the study, a convenience selection method was utilized to produce a homogeneous sample and diminish volunteer bias (Wiederman, 1999). A homogeneous sample was desired because the goal of the proposed research was to understand and describe a particular population in depth. All study procedures were reviewed and approved by the Institutional Review Board at Oklahoma State University.

Participants

Eligibility requirements for this study were that participants were at least 18 years of age and were enrolled in a course at Oklahoma State University in the College of Education, Health and Aviation which offered research participation for course credit. The online research system, SONA, was utilized to collect data. The initial sample size was 301 participants from Oklahoma State University. The final sample size was 282 after 19 participant responses were deleted for not completing the survey or incorrectly responding to validity questions throughout the measure.

Demographic analysis for the sample was completed through the use of SPSS. The average age of the students in the study was 21.72 (SD = 5.032). Participants were 93.3 % undergraduate students (Freshmen, 21.6%; Sophomores, 27.7%; Juniors, 27.0%; Seniors, 17.0%). The remaining 6.7% were graduate students, with 3.9% enrolled in a master’s program and 2.5% working toward a doctoral degree. Participants were asked to identify their caregiver’s level of education. 36.98% of respondents indicated they had at least one caregiver who obtained their bachelor’s degree and 15% of respondent’s caregivers had a master’s degree.

Table 1

		Education Classification		Valid	Cumulative
		Frequency	Percent	Percent	Percent
Valid	Freshman	61	21.6	21.6	21.6
	Sophomore	78	27.7	27.7	49.3
	Junior	76	27.0	27.0	76.2
	Senior	48	17.0	17.0	93.3
	Graduate Masters	11	3.9	3.9	97.2
	Graduate Doctoral	7	2.5	2.5	99.6
	Other	1	.4	.4	100.0
	Total	282	100.0	100.0	

The reported race of participants was: Caucasian, 70.2%; African American, 8.5%; and Native American, 8.2%. Asian, Latino, and Other were each less than 3.5% of the sample. Ethnicity identified was 93.3% Non-Hispanic and 6.7% Hispanic. Most of the participants identified as female, 62.8%. The remaining 37.2% of participants identified as male with none identifying as gender fluid or no gender. Of the sample, 95.36% identified as heterosexual. This percent, originally 91.86%, was adjusted as 3.5% identified as “other” and filled in the text section indicating they identified as “straight.” A majority of the sample indicated Oklahoma, 59.2%, as the state they were predominately raised in during their childhood. Texas, 16.7%; Don’t live in US, 6.7%; and Kansas 3.5% were the next largest responses.

Table 2

		Race		Valid	Cumulative
		Frequency	Percent	Percent	Percent
Valid	Asian/Asian American	10	3.5	3.5	3.5
	African/African American/Black	24	8.5	8.5	12.1
	Native American	23	8.2	8.2	20.2
	Caucasian/White	198	70.2	70.2	90.4
	Biracial/Multiracial	8	2.8	2.8	93.3
	Latino/a	9	3.2	3.2	96.5
	Other	10	3.5	3.5	100.0
	Total	282	100.0	100.0	

Table 3

		Relationship Status		Valid	Cumulative
		Frequency	Percent	Percent	Percent
Valid	Single	142	50.4	50.4	50.4
	Dating	108	38.3	38.3	88.7
	Engaged	13	4.6	4.6	93.3
	Married	16	5.7	5.7	98.9
	Partnered	1	.4	.4	99.3
	Divorced	2	.7	.7	100.0
	Total	282	100.0	100.0	

When asked to identify political affiliation, 43.3 percent of the sample identified as Republican. Democrat, no political identification, and Independent were the next largest groups (20.9%, 18.4%, and 10.3% respectively). Just over fifty percent of the sample identified as single and 38.3% reported dating. English was reported by 92.2% of respondents as the primary language spoken. The next highest primary language reported was Arabic at 6.7%.

Table 4

		Political Identification			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Republican	122	43.3	43.3	43.3
	Democrat	59	20.9	20.9	64.2
	Independent	29	10.3	10.3	74.5
	Libertarian	17	6.0	6.0	80.5
	None	52	18.4	18.4	98.9
	Other	3	1.1	1.1	100.0
	Total	282	100.0	100.0	

Table 5

		Primary Language			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	English	260	92.2	92.2	92.2
	Spanish	2	.7	.7	92.9
	Japanese	1	.4	.4	93.3
	Other: Arabic	19	6.7	6.7	100.0
	Total	282	100.0	100.0	

The most common religious affiliations reported were: Baptist, 23.4%; Non-denominational, 19.1%; Roman Catholic, 9.6%; Methodist, 9.6%; None, 7.4%; and Spiritual Non-religious, 5.3%. The most common family's religious affiliations reported were: Baptist, 28.4%; Non-denominational, 15.8%; Roman Catholic, 12.5%; Methodist, 11.7%; Church of Christ, 6.7%; and Muslim, 6.1%. Only 2.5% of participants indicated their families did not identify with any religious affiliation.

Table 6

		Religion		Valid	Cumulative
		Frequency	Percent	Percent	Percent
Valid	I do not have a religious affiliation	21	7.4	7.4	7.4
	Baptist	66	23.4	23.4	30.9
	Church of Christ	16	5.7	5.7	36.5
	Presbyterian	8	2.8	2.8	39.4
	Evangelical Christian	5	1.8	1.8	41.1
	Methodist	27	9.6	9.6	50.7
	Lutheran	5	1.8	1.8	52.5
	Mormon/LDS	2	.7	.7	53.2
	Non-Denominational	54	19.1	19.1	72.3
	Other Christian	9	3.2	3.2	75.5
	Roman Catholic	27	9.6	9.6	85.1
	Muslim	16	5.7	5.7	90.8
	Hindu	1	.4	.4	91.1
	Atheist	2	.7	.7	91.8
	Agnostic	5	1.8	1.8	93.6
	Spiritual not religious	15	5.3	5.3	98.9
	Other	3	1.1	1.1	100.0
	Total	282	100.0	100.0	

Procedure/Data Collection

Eligibility criteria were included in recruitment materials as well as in the informed consent. Individuals who met eligibility criteria were directed to the general information and informative process for the online Qualtrics questionnaire. Participants acknowledging informed consent were invited to participate in the study which collected responses to demographic variables and key measures of interest.

Measures

As the constructs being measured were considered sensitive, the measures were counter-balanced (randomly presented to the participant). Counterbalancing the measures was employed

to eliminate any effect that questions about sexual behaviors might have on questions about religion or religiousness and vice versa.

Sociodemographics

Sociodemographic information collected included age, race, ethnicity, gender, sexual orientation, political affiliation, primary language, educational background of participant and their caregivers, religious affiliation, religious affiliation of family, and relationship status. Age was measured on a discrete scale, while all other items were categorical or ordinal. The Duke University Religion Index (DUREL) (Koenig, Patterson, & Meador, 1997) was included in the sociodemographic section to assess for religious attendance, beliefs, and experience. The first two items on the DUREL provide multiple choices for frequency (more than once a week, once a week, a few times a month, a few times a year, once a year or less, never). The following three statements relate to religious belief and experience. The participant was provided with options to select the extent to which each statement was true (definitely true of me, tends to be true, unsure, tends not to be true, definitely not true of me).

Sexual Anxiety

Sexual anxiety was assessed using the Sexual Anxiety Scale (SAS) developed by Fallis, Gordon, and Purdon (2001). The SAS was developed in contrast to other specific assessments to focus more generally on sex related anxiety, erotophobia. The SAS is a 56-item scale that measures multiple constructs of sex anxiety. It includes statements such as “talking with my friends about my sex life” and “telling my partner what pleases me and does not please me sexually.” Responses for items are measured on a continuum (0 extremely pleasurable – 50 neutral – 100 extremely discomforting). The SAS has a Cronbach’s alpha of 0.96 and strong test retest reliability ($r=0.87$, $p<0.01$) (Fallis, Gordon, & Purdon, 2011). There are three factors

within the scale that can be measured independently, or the SAS can yield an overall score. The three individual factors are Solitary and Impersonal Sexual Expression, Exposure to Information, and Sexual Communication. The individual factor of Solitary and Impersonal Sexual Expression consists of 23 items on masturbation, pornographic and erotic material, and impersonal sexual experiences. Exposure to Information is the second individual factor which consists of 14 items on giving and receiving information about sex. The final factor of Sexual Communication consists of 16 items on openness to consensual activity and communicating sexual likes and dislikes. Higher scores on individual factors, as well as the total score, indicate greater sex anxiety (Fallis, Gordon, & Purdon, 2011). For the purpose of the current study, the overall SAS score was used as the measure of sex anxiety. In this study, Cronbach's alpha was .962.

Family Sex Communication

Family communication was measured using the Family Sex Communication Quotient (FSCQ) which has a Cronbach's alpha of 0.92 and strong internal consistency ($r=0.80$, $p<0.01$) (Warren & Neer, 1986). The FSCQ is an 18-item measure which contains three subscales (comfort, information, and value) each of which are comprised of six questions as well as an overall FSCQ. The Family Sex Communication Quotient (FSCQ) is a tool which was developed to assist in the measurement of general family orientation when discussing sex between child and parent (Warren & Neer, 1986). The participants were asked to select the option that best reflected their opinion for the given statement. The options presented were Likert type questions (strongly agree, agree, neutral, disagree, strongly disagree). Ranges indicated low, moderate, or high in each of the subscales and the overall measure.

The comfort subscale measured the participant's level of comfort and support with family when discussing sex (i.e. "I can talk to my parents about almost anything related to sex").

Information subscales measured the level of information shared between parents and child (i.e. “Much of what I know about sex I learned from family discussions”). The subscale of values was developed to address the participant’s views of parental conversation on sex which might impact their children and/or future generations (i.e. “Sex should be one of the most important topics for parents and children to discuss”). The full FSCQ ranges from low (18-39), to moderate (40-69), to high (70-90) (Warren & Neer, 1986). This study, Cronbach’s alpha was .552.

Religious Values

Religious values were assessed using the Religious Commitment Inventory -10 (RCI-10) (Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O’Connor, 2003). The RCI consists of 10 items scored on a Likert type scale to best describe the level of truth a participant places on particular statements (1 not at all true of me, 2 somewhat true of me, 3 moderately true of me, 4 mostly true of me, 5 totally true of me). Examples of questions include: “I spend time trying to grow in understanding my faith” and “Religious beliefs lie behind my whole approach to life.” Cronbach’s alpha for the RCI-10 internal consistency is .93 and test-retest consistency is .87 (Worthington et al, 2003). The total score was used for the purpose of this study. Higher scores indicate higher levels of religious values. The RCI is utilized in counseling efforts to identify the importance of religion to individuals (Wade & Worthington, 2006). Religious values, in the current study, were placed on a continuum rather than categorized and labeled. Cronbach’s alpha was .961 for the current study.

Religious Emphasis

To determine religious emphasis in childhood, the Religious Emphasis Scale (RES) was utilized as it measures parental emphasis on family religion during child rearing (Altemeyer, 1988). The RES had a Cronbach’s alpha of .92 and .58 for convergent validity (Altemeyer,

1988). Participants were given a Likert type scale (0 none at all, 1 only a little bit, 2 a mild amount, 3 a moderate amount, 4 quite a bit, 5 a great deal) to indicate the level to which their parents emphasized religion during childrearing. Some examples on the 10-item scale include: going to church, attending religious services, reviewing the teachings of the religion at home, and praying before meals. A total score was acquired by adding all of the 10 items together. Higher numbers indicate increased emphasis of religious practices during childrearing. For the purpose of this study, the directions included caregivers' emphasis during childrearing rather than parental emphasis. For the current study Cronbach's alpha was .938.

Data Analysis

SPSS (22.0) was used to perform all statistical analyses. Frequencies and percentages were calculated for categories of race, ethnicity, gender, sexual orientation, relationship status, political affiliation, primary language, educational background of participants and their caregivers, and religious affiliation of participants and their family.

A regression analysis using ordinary least squares was initially used to test the hypotheses. The linear regression was run to determine the predictive relationship of the independent variables (Family Sex Communication, Religious Emphasis During Childhood, Religious Values) on the dependent variable (Sex Anxiety). The assumptions of a linear regression—linearity and homoscedasticity—were assessed. Linearity and homoscedasticity were assessed by examination of scatter plots. The values of R^2 indicate the amount of variance in the criterion variable explained by each predictor. The F -test was conducted to determine whether the correlations were statistically significant at an alpha level of .05 and regression coefficients show the direction of the relationships.

During analysis, a violation of the assumption of multicollinearity was identified. Although the constructs differed and did not measure similar constructs (i.e. family communications about sex and religious emphasis), the violation of multicollinearity influenced the overall variance, further confounding the predicted relationship on the dependent variable. As such, a regression enter method was utilized to weigh each of the independent variables independently (Ott & Longnecker, 2001). Beta scores for each variable were reported to demonstrate the relationship between variables.

Chapter IV

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD, RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

Results

Assumption Checks

The beginning sample size was 301 students at Oklahoma State University. The data was cleaned to remove participants who did not complete the survey or who inaccurately responded to validity questions. Analysis of data identified 19 participants who met these criteria. One was deleted due to dropping out after completing the demographic questions and 18 were deleted for inaccurate responses to more than two validity questions throughout the measure. This resulted in the final sample size of 282. Initially, a linear regression was run to determine the predictive relationship of the independent variables on the dependent variable. When verifying assumptions, a violation of multicollinearity was indicated. As such, a simple enter method was utilized to determine individual relationships with independent and dependent variables. The entry method analyzed all independent variables simultaneously to determine which variables created the best prediction equation and eliminate the presence of variable overlap.

Research Questions

Research question one was, do higher levels of religious emphasis during childhood, higher levels of religious values, and lower levels of family communication predict higher levels of sex anxiety? Two of the three independent variables, family conversations about sex and religious emphasis during childhood, were highly correlated. Current religious values were not

found to be a significant predictor variable of sex anxiety. Research question two was, are low levels of family communications about sex the strongest predictor of sex anxiety? Family conversations about sex were found to be the strongest predictor variable to sex anxiety with religious emphasis during childhood being the second strongest.

Entry regression analysis was used to test if family communication about sex, religious values, or religious emphasis during childhood significantly predicted participants' level of sex anxiety. The results of the regression indicated two predictors. Family communications about sex and religious emphasis during childhood independently significantly predicted levels of sex anxiety ($R^2=.316$, $F(3,278)=10.277$, $p<.01$). It was found that family communications about sex significantly predicted levels of sex anxiety ($\beta= -2.077$, $t= -5.281$, $p<.001$). Family communication negatively predicted sex anxiety. Higher levels of communication predicted lower levels of sex anxiety and vice versa. Higher levels of religious emphasis during childhood predicted higher levels of sex anxiety ($\beta = 2.038$, $t=5.180$, $p<.001$). Current religious values were not a significant predictor of sex anxiety ($\beta = .061$, $p=.291$).

Table 7

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2501784.41	3	8347261.471	10.277	.000 ^b
	Residual	225796114.5	278	812216.239		
	Total	250837898.9	281			

a. Dependent variable: SexAnx_Tot

b. Predictors: (Constant) RelBelief_Tot, SexCom_Tot, Rel_Ch_Tot

Table 8

Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.	95% Confidence Interval for β		Collinearity Statistics	
	β	Std. Error	Beta	t		Lower Bound	Upper Bound	Tolerance	VIF
1 (Constant)	4129.992	327.416		12.614	.000	3485.464	4774.521		
Rel_Ch_Tot	299.737	57.861	2.038	5.180	.000	185.835	413.639	.021	47.798
SexCom_Tot	-149.457	28.303	-2.077	-5.281	.000	-205.173	-93.741	.021	47.773
RelBelief_Tot	4.764	4.507	.061	1.057	.291	-4.109	13.636	.958	1.015

a. Dependent Variable: SexAnx_Tot

Chapter V

THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD, RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

Discussion

The first hypothesis, that higher levels of religious emphasis during childhood, higher levels of religious values, and lower levels of family communication would predict higher levels of sex anxiety, was partially met. The independent variable of religious values was not found to be a significant predictor of sex anxiety. Family communications about sex negatively predicted levels of sex anxiety. When participants identified that they did not have conversations with their families about sex, they reported higher levels of sex anxiety. Additionally, participants with higher levels of sex anxiety indicated an increased emphasis of religion and religious practices during their childhood. Researchers who have focused on the intersection of religion and sex often highlight abstinence or avoidance as the primary approach to sex education (Sands, 2000). These methods continue to be utilized in religious households, although they have been identified as ineffective methods of education which often result in poor outcomes, such as teenage pregnancy and STIs (Strayhorn & Strayhorn, 2009).

The second hypothesis, that family communication would be the strongest predictor variable of sex anxiety, was supported. Of each of the independent variables, family communication was the strongest predictor of sex anxiety. This finding is consistent with previous research as communication is frequently noted to be the main predictive factor to

increasing education and decreasing anxiety of topics discussed (Robinson, 2013; Rostosky, Dekhtyar, Cupp, & Anderman, 2008; Warren & Neer, 1986). Communication with others is how people learn (Bronfenbrenner, 1999). According to the IMBS model learning about sex directly and indirectly influences overall sexual behaviors (Fisher & Fisher, 1998).

These findings are helpful to the field of counseling psychology as they inform us about possible factors which contribute to sex anxiety. By identifying contributing factors to sex anxiety, psychologists can provide preventative interventions. With the present data, psychologists working with a religious family could encourage communication within the home while maintaining the importance of being culturally sensitive and not imposing one's cultural biases onto clients. The factor of religious emphasis during childrearing is more complicated to address in practice. While working with the identified populations, psychologists could provide education on the relationship between communication and sex anxiety and work with families to provide additional interventions in an effort to combat sex anxiety. Anxiety with sex and sex related information influences sexual behaviors. Some behaviors can have detrimental impacts on a person's life.

Limited communication on sex and sex related information results in limited and inadequate sexual knowledge. Poor information can be dangerous as people become susceptible to unintended pregnancies and sexually transmitted infections, such as HIV. Lack of education and information is linked to increasing this vulnerability. Identifying the relationship between limited family communication and increased sex anxiety demonstrates the importance of sex education and conversations about sex in the home.

Applying the IMBS model demonstrates that this cycle will continue through each generation. A person who has decreased family communications about sex and increased levels of sex anxiety is more likely to not have family communications with their children (Fisher & Fisher, 1998). In addition, if a family's cultural practice is increased levels of religious emphasis during child rearing, levels of sex anxiety is likely to continue. This means that the cycle of ignorance and poor education continues throughout generations.

Counseling psychologists play an important role in preventing this perpetual cycle. Education and training are effective tools to changing the pattern of behavior and passing sex anxiety throughout generations. Education on a subject decreases anxiety about the subject (Bondy, Sims, Schroeder, Offord, & Narr, 1999). Counseling psychologists can work toward decreasing sex anxiety by increasing education on sex and sexual related behaviors. One method of increasing education and support within the individual's ecological system is to utilize their protective factors and support networks. Religious entities and family can be a great means of support and education. The results of this study showed that lower levels of family communication on sex predicted increased levels of sex anxiety, yet, the opposite is also true. This relationship can be used as a protective factor. Counseling psychologists can work with the family to increase communication, thereby decreasing anxiety.

Often, ambivalent or dichotomous thinking is present when discussing the importance of providing sex education. On one end of the spectrum there is anxiety that sex education will result in oversexualization or inappropriate sexual behaviors (Rohleder, 2010). This is often the case when religion is incorporated into family culture in the United States. On the opposite end of the spectrum it is easily identified that sex education is an important aspect of growth and development. Within the family system there are multiple constructs which influence the

decision for parents and families to discuss sex related topics. Parents who identify sex education as important but may not have a frame of reference or feel as though their skills are limited, are less likely or unable to provide adequate education (Fisher & Fisher, 1998). This dichotomous educational approach results in too much or too little education. Unfortunately, the former is most common, especially in more religious environments. In the realms of sex education many could benefit from the incorporation of a grey area. The black and white all or none thinking of sex education leaves a lot to be desired. Impromptu polls conducted on the streets of major cities identified that many women polled were unable to correctly respond to the question of; “how many holes are there [within the female genitalia].” In addition, many of the male and female participants could not properly label the parts of a woman’s genitals (i.e. labia, clitoris).

This study sought to address anxiety as a whole, both physical and emotional aspects, in an effort to measure general anxiety towards sex. In previous literature, the term sex anxiety has often been only to refer to physical symptoms or inability to perform sexually. The Sex Anxiety Scale was developed in contrast to other assessments to focus more generally on sex related anxiety, erotophobia, rather than physiological factors. Past research did not address sex anxiety in the general sense but rather physical complications such as vaginismus and erectile dysfunction (Hertlein, Weeks, & Gambescia, 2009). Communication about sex has been identified as an important education tool for children learning about sex (Warren & Neer, 1985). For the individual to function in a healthy way, communication within the family structure is not only beneficial, it is imperative for the individual’s ecological system (Galvin, Braithwaite, & Bylund, 2015).

With so many cultures and unique experiences for children, no learning environment can truly be replicated, controlled, or manipulated (Mahn, 2000). Considering these various factors

and multiple outcomes, research is necessary to assess how professionals within the mental health field make changes, apply preventative measures, and help those in need on a larger scale (Reifsnider, Gallagher, & Forgione, 2005). Previous research suggests the best possibility to make a difference on learning is by having all components of the individual's life facilitate growth and meaningful change (Bruess & Schroeder, 2014; Sands, 2000). To diminish anxiety, sexual dysfunctions related to anxiety, misinformation, and lack of education, an emphasis must be placed on improving the systems which both directly and indirectly impact the person (Bruess & Schroeder, 2014; Luker, 2006; Moran, 2000; Sands, 2000).

Results from this study give researchers and clinicians a better understanding of contributing factors to sex anxiety. This information could improve programming developed to prevent sex anxiety. Trainings and outreach efforts for counseling psychologists could include psychoeducation on sex education for parents and agencies working with children. Future research avenues could include effective program development for working with families and children to diminish sex anxiety. Additional research foci could include a more in-depth emphasis on social relationships throughout development which might influence sex anxiety. A strong correlation between family communication and sex anxiety informs counseling psychologists about the importance of implementing effective communication methods with families they serve when discussing sexual health related topics.

Limitations

Limitations addressed in this study included limited application of dependent variable measure, sensitivity of constructs being measured, convenience sampling, and grouping of religious entities. With regard to the dependent variable measure, the Sex Anxiety Scale (SAS) had strong internal consistency, however, it lacked multiple comparisons of similar assessments.

The authors of the assessment indicated there are no other studies to make comparisons as it measures anxiety specifically with regard to sex (Fallis, Gordon, & Purdon, 2011). Additionally, sex anxiety when compared to religious affiliation and values can be considered sensitive and may have confounded the data as the subjects may not have been entirely honest (Sands, 2000).

Another potential limitation for the study was the use of a convenience sample of college students as participants which results in a homogenous sample decreasing generalization. On the contrary, college samples can have a large amount of diversity (Druckman, & Kam, 2009). Finally, by grouping religious entities together (Christian, Muslim, Protestant, etc.) there may be overgeneralizations about religious categories which can result in stereotypes such as certain groups being more conservative and creating anxiety about sex and sexuality (Sands, 2000). While this does occur, there is an evident need within the existing literature to view religiosity as a spectrum rather than collapse the groups together by category (Brunn, Webster, & Archer, 2011). Utility of a spectrum could assist in demonstrating that religious groups may be more dissimilar than they are similar. Particularly, messages gathered during childhood, ideals of religious values, and family communication provide a more accurate depiction of religiosity than adoption of a label. An additional limitation of this study is the low Cronbach's alpha of .552 for family sex communication. The Family Sex Communication Quotient was found to have strong internal consistency ($r=0.80$, $p<0.01$) and a Cronbach's alpha of 0.92 (Warren & Neer, 1986). The lower alpha in the current study could be a result of pairing religious values with family sex communication or inconsistent responding by participants. In future studies researchers could utilize additional measures for communication within the family system.

A homogenous sample was desired for this study due to the explorative nature. However, as a result, the diversity in religious identification was lower than expected. Approximately a

quarter of the sample identified as Baptist or Southern Baptist. This limitation in religious diversity impacts the generalizability for religious impacts on sex anxiety in other religions.

Implications

Counseling psychologist conducting future research in the area of sex anxiety should focus on the importance of communication within the family. Individuals learn from their environment through conversations and behaviors within the home. It is imperative for psychologist working with the families to provide education and interventions of communication to end the cycle of misinformation. Advocacy efforts for decreasing sex anxiety could include presentations to effected populations. Some religious entities have begun to provide education and trainings for their communities. These efforts would be an excellent medium for breaking the cycle of sex anxiety.

Developing positive sexual and reproductive health behaviors through the IMBS model begins with increasing sex health information and motivation (Fisher & Fisher, 1998). Implications for future research should include a stronger emphasis on other constructs, such as friends or peers, within the individual's social networks (Rosenthal, Smith, & De Visser, 1999). While gender is reported in this study, a more in-depth focus in future studies on gender differences could be further investigated as gender differences have been identified as potential contributing factors (Sprecher, Barbee, & Schwartz, 1995). There were no notable between-groups differences based on gender when analyzing sex anxiety.

In summary, previous researchers have identified erotophobia as a learned disposition resulting from an individual's socialization (Fisher, White, Byrne, & Kelley, 1988). Current researchers continue to identify anxiety's debilitating effect on the individual (Kempeneers,

Pallincourt, & Blairy, 2009). Increased exposure and education to sexual health result in a decrease in anxiety and anxiety related concerns with regard to sex (Wright & Cullen, 2001). Increased interventions, awareness, and education will assist in decreasing sex anxiety. This is just the beginning of what can be done to address the factors which contribute to an individual experiencing sex anxiety. Sex, currently, is essential to human life. It is part of the human experience. Sex anxiety impacts more than just the individual. If we can reduce sex anxiety through education and communication, let's talk about sex.

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APPENDICES

Appendix A **Informed Consent**

Project Title: Communication, Religion, and Anxiety

Researcher: *Ashlee Jayne M.S.*

This survey will take approximately 40 minutes. The purpose of this study is to explore factors related to an individual's anxiety. The data collected will hopefully assist in furthering and informing future projects.

This survey consists of some questions which could be uncomfortable to answer. To minimize this potential discomfort, please remember that your answers are completely anonymous. You may refuse to answer any question and you may end your participation in the study at any time. All information collected will be reported in aggregate (grouped) form; no individual responses will be reported. A counseling resource list is available at the end of the survey.

The records of this study will be kept private. Any written results will discuss group findings and will not include information that will identify you. Research records will be stored securely and only researchers and individuals responsible for research oversight will have access to the records. It is possible that the consent process and data collection will be observed by research oversight staff responsible for safeguarding the rights and wellbeing of people who participate in research.

There are no known risks associated with this project which are greater than those ordinarily encountered in daily life. Participation in this study is voluntary. You will not be penalized for ending your participation in the study at any time. If you have any questions, concerns, or would like a copy of the results of the study, please contact the researcher.

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If you have questions about your rights as a research volunteer, you may contact Dr. Hugh Crethar, IRB Chair, 219 Cordell North, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu.

Are you 18 years of age or older? Yes No

Do you understand what is required of you and agree to participate in this survey? Yes No

By continuing I acknowledge that I have read and fully understand this consent form.

Appendix B

Demographics

Please answer the following questions. All answers are completely anonymous and will be reported in group format.

What is your age? _____

What is your Ethnicity?

- Hispanic
- Non-Hispanic

What is your Race?

- Asian/Asian American
- African/African American/Black
- Native American/American Indian/Alaska Native
- Native Hawaiian/Pacific Islander
- Caucasian/White
- Biracial/Multiracial
- Other: (please specify) _____

What is your Gender?

- Female
- Male
- Other (please specify): _____

What is your Sexual Orientation?

- Lesbian
- Gay
- Bisexual
- Heterosexual
- Other (please specify): _____

What State were you raised in (most of your childhood): (list states; other: _____)

What is your primary language (i.e., the one you speak most of the time)?

- English
- Spanish
- Chinese
- French
- German
- Dutch
- Japanese
- Hebrew
- Swedish
- Other (please specify)

What is your primary religious affiliation?

- I do not have a religious affiliation
- Baptist
- Church of Christ
- Presbyterian
- Evangelical Christian
- Methodist
- Unitarian Universalist
- Lutheran
- Mormon/LDS
- Non-Denominational
- Other Christian (please specify):

- Roman Catholic
- Jewish
- Muslim
- Hindu
- Buddhist
- Atheist
- Agnostic
- Wicca
- Spiritual not religious
- Other (please specify): _____

What is your family's primary religious affiliation? If you have more than one for your family please mark all that apply.

- They do not have a religious affiliation
- Baptist
- Church of Christ
- Presbyterian
- Evangelical Christian
- Methodist
- Unitarian Universalist
- Lutheran
- Mormon/LDS
- Non-Denominational
- Other Christian (please specify):

- Roman Catholic
- Jewish
- Muslim
- Hindu
- Buddhist
- Atheist
- Agnostic
- Wicca
- Spiritual not religious
- Other (please specify): _____

How would you describe your feelings about religion?

- Positive
- Somewhat Positive
- Neutral
- Somewhat Negative
- Negative
- This question does not apply to me.

How would you describe your religion's feelings about you?

- Positive
- Somewhat Positive

- Neutral
- Somewhat Negative
- Negative
- This question does not apply to me.

Apart from events such as weddings and funerals, how often do you attend religious services?

- More than once a week
- Once a week
- Once or twice a month
- A few times a year
- Never

How many caregivers/parents/guardians raised you? 1-2-3-4-5-6

What is caregiver/guardians/parent's highest level of formal education? (x # of caregivers)

- Some schooling (no degree or diploma)
- High school diploma / GED
- Some college
- Associates degree / Trade school certification
- Bachelors degree
- Masters degree
- Doctoral degree
- Other professional degree or certification please specify_____

What is your current classification?

- Freshman
- Sophomore
- Junior
- Senior
- Graduate Special Student
- Graduate Masters Level
- Graduate Doctorate Level
- Other please specify_____

What is your political party identification?

- Republican
- Democrat
- Independent
- Libertarian
- Other _____
- None

What is your relationship status?

- Single
- Dating
- Engaged
- Married
- Partnered
- Separated
- Divorced
- Widowed

Duke University Religion Index (DUREL)

1. How often do you attend church or other religious meetings?
 - More than once a week
 - Once a week
 - A few times a month
 - A few times a year
 - Once a year or less
 - Never
2. How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?
 - More than once a day
 - Daily
 - Two or more times/week
 - Once a week
 - A few times a month
 - Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. In my life, I experience the presence of the Divine (i.e., God).
 - Definitely true of me
 - Tends to be true
 - Unsure
 - Tends *not* to be true
 - Definitely *not* true
4. My religious beliefs are what really lies behind my whole approach to life.
 - Definitely true of me
 - Tends to be true
 - Unsure
 - Tends *not* to be true
 - Definitely *not* true
5. I try hard to carry my religion over into all other dealings in life.
 - Definitely true of me
 - Tends to be true
 - Unsure
 - Tends *not* to be true
 - Definitely *not* true

Appendix C

Religious Emphasis Measure

Please indicate how much your parents emphasized the following items while you were growing up:

- 0 = no emphasis was placed on the behavior
- 1 = a slight emphasis was placed on the behavior
- 2 = a mild emphasis was placed on the behavior
- 3 = a moderate emphasis was placed on the behavior
- 4 = a strong emphasis was placed on the behavior
- 5 = a very strong emphasis was placed on the behavior

1. Going to church; attending religious services.
2. Attending “Sunday school”; getting systematic religious instruction regularly.
3. Reviewing the teachings of the religion at home.
4. Praying before meals.
5. Reading Scripture or other religious material.
6. Praying before bedtime.
7. Discussing moral “do’s” and “don’t’s” in religious terms.
8. Observing religious holidays; celebrating events like Christmas in a religious way.
9. Being a good representative of the faith; acting the way a devout member of your religion would be expected to act.
10. Taking part in religious youth groups.

Appendix D

Religious Commitment Inventory (RCI)

Instructions: Read each of the following statements. Using the scale to the right, circle (select) the response that best describes how true each statement is for you.

1 = Not at all true of me

2 = Somewhat true of me

3 = Moderately true of me

4 = Mostly true of me

5 = Totally true of me

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious affiliation.
10. I keep well informed about my local religious group and have some influence in its decisions.

Appendix E

Family Sex Communication Quotient (FSCQ)

The following statements represent personal feelings about family discussions of sex. Please mark one of the five response categories that best describes your opinion.

1 = Strongly disagree

2 = Disagree

3 = Neutral

4 = Agree

5 = Strongly Agree

1. Sex should be one of the most important topics for parents and children to discuss.
2. I can talk to my parents about almost anything related to sex.
3. My parents know what I think about sex.
4. It is not necessary to talk to my parents about sex.
5. I can talk openly and honestly with my parents about sex.
6. I know what my parents think about sex.
7. The home should be a primary place for learning about sex.
8. I feel comfortable discussing sex with my parents.
9. My parents have given me very little information about sex.
10. Sex is too personal a topic to discuss with my parents.
11. My parents feel comfortable discussing sex with me.
12. Much of what I know about sex has come from family discussions.
13. Sex should not be discussed in the family unless there is a problem to resolve.
14. Sex is too hard a topic to discuss with my parents.
15. I feel better informed about sex if I talk to my parents.
16. The least important thing to discuss with my parents is sex.
17. I feel free to ask my parents questions about sex.
18. When I want to know something about sex, I generally ask my parents.

Appendix F

Sexual Anxiety Scale (SAS)

Please rank your level of discomfort you would experience using the following scale
0 extremely pleasurable – 50 neutral – 100 extremely discomforting

1. Wearing clothes that show off my sexually attractive features
2. Seeing two people kissing or fondling each other
3. Watching a movie scene from a major box office movie in which people were naked
4. Talking with my friends about my sex life
5. Masturbating
6. Looking at hardcore or pornographic photos in a magazine (explicit scenes of genitals and penetration)
7. Using sex toys, such as a vibrator, during sex with my partner
8. Exploring the erogenous, or sexual exciting, parts of my partner's body
9. Hearing about someone engaging in a consensual sexual act that I personally would never want to engage in
10. Discussing my sexual fantasies with my partner
11. Having arousing sexual thoughts that are unrelated to my current sexual partner
12. Hearing about a woman who enjoyed sex and was sexually adventurous
13. Watching a "hardcore" or "pornographic" film
14. Being exposed to information about sexually transmitted infections
15. Kissing or fondling my partner in a public place
16. Vocalizing my pleasure during sex with my partner
17. Watching a movie scene from a major box office movie in which people were kissing or fondling each other
18. Hearing about someone who has a biological sexual abnormality, such as undescended testicles or a fertility problem
19. Reading book with sexually explicit passages.
20. Agreeing to try sexual activities or positions that I find unusual but my partner suggests
21. Using sex toys, such as a vibrator, when I am alone
22. Engaging in foreplay with my partner
23. Finding myself becoming sexually aroused in response to something I never would have expected myself to be aroused by
24. Visiting Internet sites that feature erotic or softcore photos or video clips
25. Having arousing sexual thoughts that are related to my current sexual partner
26. Talking with my partner about his/her sexual fantasies
27. Talking with my friends about general matters of a sexual nature, such as menstruation, pregnancy, childbirth
28. Changing my clothes in a public change room that does not have privacy cubicles
29. Being exposed to information about contraceptive devices that require intimate genital contact (e.g., diaphragm, sponge, foam)
30. Overhearing other people (not parents) having sex
31. Watching a scene from a major box office movie in which people were engaging in sex

32. Exploring erogenous, or sexually exciting, parts of my body when I am alone
33. Someone knowing that I look at/watch erotic photos/films
34. Suggesting new sexual activities or positions to my partner
35. Visiting Internet sites that features hardcore or pornographic photos or video clips
36. Engaging in a casual sexual encounter (e.g., one-night stand)
37. Being invited by an acquaintance/friend/partner to engage in an unusual sexual act
38. Hearing about sexual issues or matters from the newspaper or TV
39. Fantasizing about arousing sexual acts during sex with my partner in order to enhance my excitement
40. Disclosing to my friends that I have a sexual problem
41. Answering questions about sexual matters such as conception
42. Someone overhearing me and my partner having sex
43. Being around others who are changing their clothes
44. Being exposed to information about diseases of the sex organs, such as cervical cancer, testicular cancer, prostate cancer, breast cancer
45. Watching an “erotic” or “softporn” film (no explicit scenes of the genitals or penetration)
46. Allowing my partner to explore my erogenous, or sexually exciting, parts of my body
47. Someone knowing that I look at/watch pornographic photos/films
48. Changing activities or positions during sex with a partner to help ensure that I have an orgasm
49. Looking at erotic or softcore photos in a magazine
50. Telling my partner what pleases me and does not please me sexually
51. Hearing about people I don’t consider to be sexual engaging in sex, such as the elderly, my parents, disabled people
52. Fantasizing about arousing sexual thoughts during masturbation in order to enhance my sexual excitement
53. Watching coverage of the Gay Pride Day parade
54. Being exposed to information about contraceptives and contraceptive use
55. Completing questionnaires about my sexuality

Appendix G

Resource List for Participants

If you feel you would like to speak to someone about any thoughts or feelings that might have occurred in relation to the questions asked in this survey, please feel free to contact any one of the agencies listed below.

Counseling Psychology Clinic

111 PIO Building

(405) 744-6980

<http://education.okstate.edu/index.php/counseling-psychology-clinic>

University Counseling Services

316 Student Union

(405) 744-5472

Psychological Services Center

118 North Murray Hall

(405) 744-5975

Center for Family Services

101 HES West

(405) 744-5058

If you would like information about counseling resources located in the Stillwater community, please contact 211 or visit 211oklahoma.org

Appendix H
IRB Approval

Oklahoma State University Institutional Review Board

Date: Tuesday, December 12, 2017
IRB Application No: ED17144
Proposal Title: The Relationship of Religious Emphasis During Childhood, Religious Values,
and Family Conversations with Sex Anxiety

Reviewed and Expedited
Processed as:

Status Recommended by Reviewer(s): Approved Protocol Expires: 12/11/2018

Principal
Investigator(s):

Ashlee Jayne	Julie Koch
P.O. Box 4	418 Willard
Stillwater, OK 74076	Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval. Protocol modifications requiring approval may include changes to the title, PI advisor, funding status or sponsor, subject population composition or size, recruitment, inclusion/exclusion criteria, research site, research procedures and consent/assent process or forms
2. Submit a request for continuation if the study extends beyond the approval period. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of the research; and
4. Notify the IRB office in writing when your research project is complete.

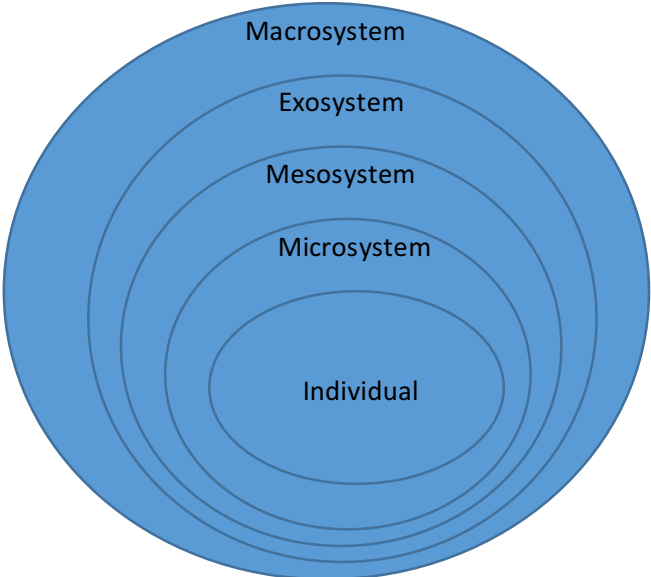
Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Dawnett Watkins 219 Scott Hall (phone: 405-744-5700, dawnett.watkins@okstate.edu).

Sincerely,


Hugh Cretnar, Chair
Institutional Review Board

Appendix I
Theoretical Constructs

Figure 1



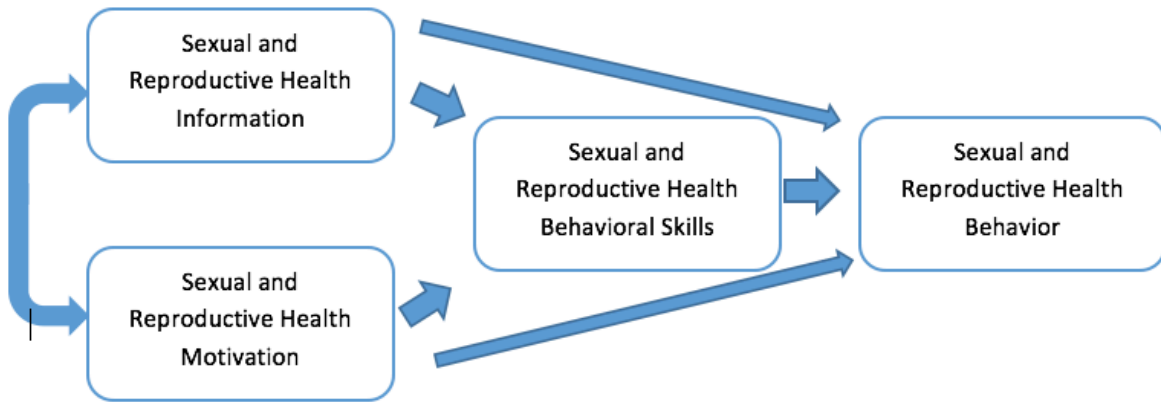
(Bronfenbrenner, 1999).

Figure 2



(Bronfenbrenner, 1999).

Figure 3



(Fisher & Fisher, 1998).

Figure 4

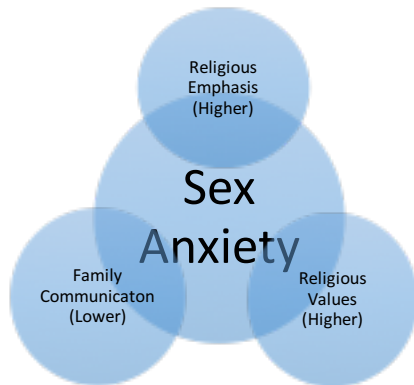
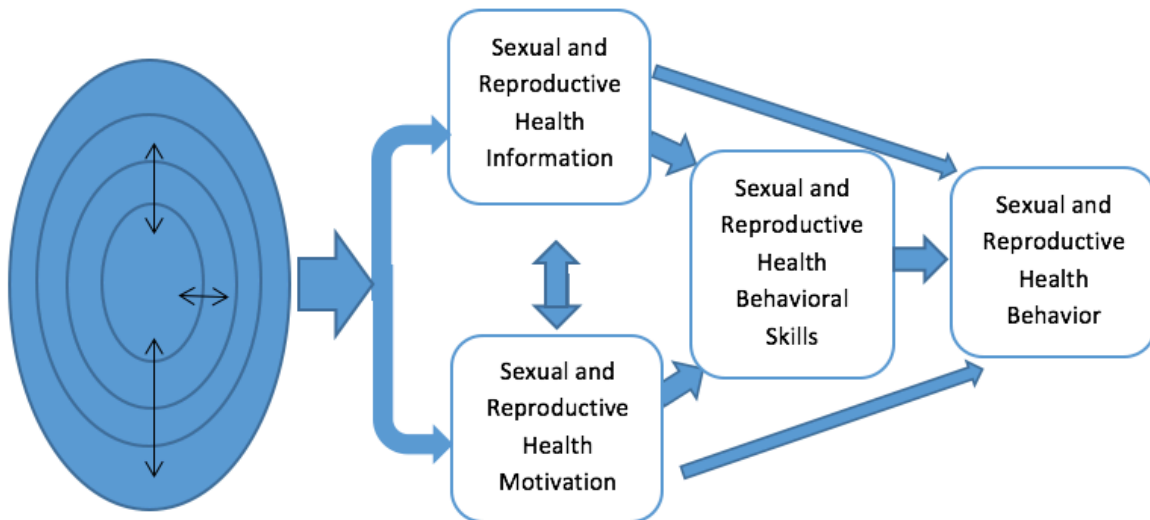


Figure 5



VITA

Ashlee Lawren Jayne

Candidate for the Degree of

Doctor of Philosophy

Dissertation: THE RELATIONSHIP OF RELIGIOUS EMPHASIS DURING CHILDHOOD,
RELIGIOUS VALUES, AND FAMILY CONVERSATIONS WITH SEX ANXIETY

Major Field: Counseling Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Education in
Counseling Psychology at Oklahoma State University Stillwater, Oklahoma in
July 2019

Completed the requirements for Master of Science in Psychology
Oklahoma State University, Stillwater, Oklahoma in 2014

Completed the requirements for Bachelor of Science in Psychology
Oklahoma State University, Stillwater, Oklahoma in 2011

Experience:

Internship – United States Medical Center for Federal Prisoners Springfield, Missouri
APA Accredited Internship

Professional Memberships:

American Psychological Association