n reported being either very or moderately satisfied with their sexual lationship, and 83% rated their marriage as very happy or happy. The *edbook* survey of middle-class women (Tavris & Sadd, 1977) found that 7% rated the sexual aspect of their marriage as either very good or ood, with 80% reporting their marital relationship as very good or ood. Hunt (1974) found that a large majority of married men and mar- ed women for whom marital sex had been very pleasurable in the past ear rated their marriages as very close. Hunt stated that there was little loubt in his mind that a cause-and-effect relationship exists between exual pleasure in marriage and the overall success of the marital rela- ionship: However, he did not profess to know which is cause and which s effect. Our data also indicated a strong relationship between these two ariables (r = .80). Thus, it appears that regardless of socioeconomic tatus, there is a strong relationship between sexual and marital satisfac- ion. It will require further research to delineate the issue of cause and ffect between these two variables.

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Considering the Adolescent's Point of View: A Marketing Model for Sex Education

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Sex education programs to date have been relatively ineffective in bringing about desired changes in adolescent sexual behavior. One reason may lie in the tendency of the programs to reflect salient concerns of adults rather than those of the adolescent target group. It is suggested that better results could be achieved if a marketing model is used by program developers. The model places greater emphasis upon the perceived needs and problems of the adolescent consumer. Research in business and consumer psychology has shown the effectiveness of such a consumer-oriented focus. Support is found in related research dealing with adolescent smoking. Application of these ideas to sex education are discussed with illustrative data.

Whether and to what extent sex education should be included in school curricula has long been a controversial issue in the United States. Although many school districts offer some form of instruction in sex education, course content varies enormously. Some curricula focus simply on teaching about the "plumbing" of the reproductive system, others are designed to instill the value of abstinence before marriage, and still others place sexuality in the context of self-esteem and of interpersonal relationships. This article contributes to the discussion of sex education curricula by suggesting that a marketing model be adopted in the design of programs to teach adolescents about sexuality. First, the content of sex education is reviewed with some statistics on adolescent sexual behavior. Then a distinction is drawn between an adult-focused and an adolescent-focused perspective on teenage sexuality. An argument is then made for exploring the potential of the adolescent perspective in developing programs for sex education.

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BACKGROUND INFORMATION

There is evidence that exposure to sex education curricula has little effect on adolescents' sexual behavior. The adolescent pregnancy rate in the United States is higher than that of most of the world's developed nations (Jones, Forrest, Goldman, Henshaw, Lincoln, Rosoff, Westoff, & Wulf, 1985). Each year more than 1 million American adolescents conceive—over 10% of all teenage women. Approximately 80% of these women are unmarried at the time, and some 30,000 are under 15 years of age (Mecklenburg & Thompson, 1983; Wallis, 1985). Half of all premarital pregnancies occur in the first 6 months of sexual activity, yet surveys of contraceptive use reveal that between one third and two thirds of adolescents used no contraception at first intercourse. Condoms are among the contraceptive techniques most frequently used by teenagers. Given the prevalence of acquired immune deficiency syndrome (AIDS) in the population (Shayne & Kaplan, 1988), one would hope that condom use was widespread among youths who engage in intercourse. However, surveys from the 1970s indicated that 20–25% of all sexually active teenagers *never* used a contraceptive technique of any kind, and about half reported using such a technique only sometimes (Morrison, 1985). It would be overly optimistic to expect a dramatic increase in this percentage for comparable but more recent surveys.

The problem of unprotected sexual activity among teenagers can be attacked from several perspectives. Perhaps the common response is to conclude that adolescents lack sufficient knowledge about their bodies and about available contraceptive measures. That they are misinformed about the sexual aspects of their physiology is well documented. Morrison (1985), for example, reports data from eight surveys in which respondents were asked to identify the period of greatest risk of pregnancy during the menstrual cycle. Overall, fewer than half of the subjects knew the correct answer. In fact in one study, most believed that the risk of pregnancy is greatest *during* menstruation (Zelnick & Kantner, 1977).

If misinformation about contraception is a major part of the problem, we should ask where, and from whom, do adolescents learn about contraception. When adolescents are asked this question, we usually find that parents are among the least important of information sources. Peers, books, and medical professionals are the most common sources. Sex education classes are mentioned infrequently (except by college students) (Andre, Frevert, & Schuchmann, 1989). This is disturbing given that frequently one of the main objectives of such classes is to provide information about how pregnancy occurs and how it can be prevented. Studies of adolescents who have been exposed to sex education indicate that such students are more knowledgeable than others. However, the impact of sex education classes is weak. For example, with regard to knowledge of the period of greatest fertility during the menstrual cycle, sex education classes add only about 10% to the percentage of subjects having this knowledge (Morrison, 1985).

DIFFERENCES IN PERSPECTIVE

Adolescent pregnancy is viewed here as primarily a behavior change problem. The problem is that adolescents are engaging in sexual intercourse without use of effective contraceptive techniques. The target behaviors have been exceedingly difficult to change to date. Similar humbling conclusions have been drawn from efforts to deal with cigarette smoking (Leventhal & Cleary, 1980) and substance abuse (Nathan, 1983). Some research suggests that young teenagers have not adopted sexually responsible behaviors following sex education because they simply have not reached the necessary level of cognitive development (Holmbeck, Gasiewski, & Crossman, 1989; Pestrak & Martin, 1985). Prescriptive elements of sex education programs may assume that the teenager is operating at an adult level when in fact this is not the case. In other words, program developers may at least implicitly operate on the assumption that the adolescent shares the adult's world view when this may not be the case. It may be instructive to examine some of the differences between the perspective of the adult and that of the adolescent.

One major difference between the adult's perspective and the adolescent's perspective is that adults place greater emphasis on the *long-term consequences* of actions. Unprotected sexual activity has a number of potential long-term consequences such as pregnancy and sexually transmitted disease. The probability of any specific sexual event leading to one of these outcomes may be low; however, this probability increases as the number of events increases. One sexual adventure is unlikely to result in development of AIDS; chances of contracting this disease increase if a person maintains a habit of promiscuous, unprotected sexual adventures. It seems reasonable to adults that one should place high value on the future health consequences of one's behavior. To the adolescent, long-term consequences of current actions may be too remote and abstract to effectively guide current behavior. In support, a midwestern survey of over 5000 teenagers found that colds and depression were among the leading health concerns acknowledged by adolescents. Sexually transmitted diseases and pregnancy were among the least noted health problems (Blum, 1987). Teenagers take action only for the more concrete or immediate forms of illness and disability. The notion of prevention is an abstract concept that entails taking action now in order to increase the probability of desirable consequences sometime in the fu-

ture. Preventive behaviors are more in accordance with the long-term perspective of the adult than of the short-term perspective of the teenager (Hein, 1988).

Adults' concern for teenagers who fail to practice contraception when they engage in sex extends beyond the desire to prevent pregnancy and the spread of sexually transmitted diseases. Adults understand that early pregnancy can restrict or severely limit educational opportunities, career development, financial independence, and the resources available to children of adolescent parents. The adolescent may be relatively unconcerned with such abstract issues. From the perspective of the adolescent, more immediate and concrete concerns may loom largest. Current behavior may be guided primarily by the current emotional state, current group norms, and the short-term consequences of actions.

Although other differences may be identified between the viewpoints of adolescents and adults, this difference in length of effective time span will suffice for the argument of this paper. It is suggested that sex education programs are based on the perspective and values typical of adult curriculum developers. Such curricula may prove more successful in achieving their intended objectives (informational, attitudinal, and behavioral) *if* the perspective of adolescents were made an integral and primary characteristic of the curriculum.

THE MARKETING MODEL

Sex education is more than simply a means of providing increased knowledge to students. Sex education programs involve implicit (if not explicit) attitudes, values, and behaviors. That is, such programs can be viewed as designed to change attitudes and behaviors in directions deemed desirable by parents, teachers, and health care professionals. To the extent that these are in fact behavior change programs, they have characteristics in common with programs in the business world.

In business, providers of goods and services are confronted with the need to bring about changes in attitudes and behaviors of target consumer groups. The attitudes of consumers must be changed so as to accommodate product information, favorable opinions with respect to the desirability of the product, and an intention to purchase the product if the means are available. The goal is to change consumer behavior in the direction of greater likelihood of product purchase.

Businesses have had considerable success applying a marketing model to bring about desired attitude and behavior changes. Research is conducted to identify the problems and needs of various consumer groups. Businesses then use the results of this research to develop products and services that will address the needs of the consumers. It is

crucial to note here that the marketing model uses the consumers' perceived needs as a starting point. Researchers must identify problems and needs that are salient in the minds of the consumers. Products and services are developed that solve the consumers' perceived problems and meet the consumers' perceived needs. Following this model, the consumer is sovereign. If the consumer considers the product or service to be lacking in personal utility, no purchase follows. It is sometimes thought that businesses can create a need for products by overpowering the "defenseless" consumer with advertising. Such a strategy is risky and often ends in failure. In this regard, some will remember the Ford Edsel, which failed following just such a marketing strategy. The auto company's clever and expensive media blitz failed to convince the public to buy the car.

The marketing model has been described in some detail in the consumer behavior literature (Engel, Blackwell, & Miniard, 1990). It incorporates several well-known psychological components. These include the widely accepted human cognition models of information processing and decision making. For our purposes, the main point to be gained is that organizations involved in the business of changing attitudes and behavior have been notably successful when they have taken the concerns and perceived needs of the target group as a primary point of departure. When the consumers have not been taken seriously and given primacy, experience has revealed the behavior change ventures to be risky and often doomed to failure.

It is suggested here that designers of curricula in sex education might find program benefits if they adopted the marketing approach.

PROMISING TREND IN ANTISMOKING PROGRAMS

Some elements of the marketing model have appeared in programs designed to prevent cigarette smoking in children. Fielding (1985) outlined characteristics of the newer smoking control strategy. These include a focus on the immediate physiological and biochemical consequences of smoking. The programs deal with social influences on smoking and help students to acquire the behavioral skills required to resist these influences. Data are presented to confront student perceptions that smoking is common in their peer group, or that it confers positive attributes.

The Minnesota Smoking Prevention Program, which incorporated a number of the ideas mentioned in Fielding's review, is described here (Murray, Luepker, Johnson, & Mittelmark, 1984). The Minnesota program involved the entire seventh grade enrollments in 10 junior high schools. Students attended five classroom sessions spaced over several months. The research design allowed for comparison of several program

variations. One comparison of interest here involved the short-term versus long-term time frames. The long-term influences intervention emphasized knowledge of the long-term health risks of smoking. The short-term-influences intervention focused on the social forces that encourage smoking onset. The latter emphasized the negative short-term social and physiological consequences of smoking. In particular, it dealt with (*a*) negative short-term consequences of smoking, (*b*) social forces encouraging smoking onset, and (*c*) teaching of social skills to resist peer and media pressure to smoke. The results showed that, for students who had not yet begun to smoke, the focus on short-term consequences produced superior results (on before–after measures of cigarette smoking).

Another intervention in the same study involved comparison of same-age peer opinion leaders with adult teachers as group leaders for classroom activities. The peer leaders were selected by their classmates and were trained during two visits to the university campus. The peer-led groups had better results (again, only for nonsmokers). For this latter comparison, only the short-term variation of the program was used. Hence, peer-led groups provided enhanced program effectiveness independent of the advantages obtained with the short-term focus.

APPLICATION TO SEX EDUCATION PROGRAMS

Characteristics of the more successful antismoking programs are congruent with the consumer-oriented focus of the marketing model. This raises the possibility that similar gains could be obtained if such an approach were applied to the problem of sex education and responsible adolescent sexual behavior.

The marketing approach suggested here begins with research on the sex-related concerns of adolescents. One purpose of sex education is to provide information and increase knowledge about sexuality. Curriculum developers must start with data indicating the types of questions adolescents have about sex. One such survey demonstrated that the types of questions in children's minds differed depending upon the age and sex of the child (Campbell & Campbell, 1986, 1988). For example, males exhibited greater interest in slang terms and profanity whereas females asked more questions about communication and sexual relationships. Other survey research has dealt with sex-related perceptions of specific minority groups (e.g., Banks & Wilson, 1989). Data from such surveys can be used to identify the perceived informational needs of adolescents. Informational programs that start with and emphasize these needs can be expected to involve and influence adolescents to a greater degree than programs based upon an adult perspective.

The content of many sex education curricula is at variance with the concerns of adolescents. Certain "sensitive" topics are often avoided—among these are homosexuality, abortion, and sometimes masturbation. Yet the Campbell data indicate that such "disallowed" topics are of considerable interest to adolescents. Children from the seventh through tenth grades in particular want to know about homosexuality. They are personally interested in how to regard specific behaviors. They want to know what should be considered homosexual and what should be considered "normal." Disallowing the topic of abortion may have serious consequences. Many young adolescents learn about abortion only when a friend (or they themselves) require the procedure. Sex education programs have generally failed to inform teens in advance about abortions and on where to obtain counselling on the options, ethics, and personal consequences involved.

Sex education often encourages abstinence as the way to deal with sexual urges. This is particularly true of programs supported by federal- and state-funded sources. Yet the fact is that many children are sexually active. Once they become active, they generally remain so. In the Campbell data, questions on abstinence were notably absent. The closest were questions from girls asking, for example, "How do you tell a guy you just want to be friends (rather than have an intimate, sexual relationship)." The limits of high-powered advertising were mentioned previously in the context of the Ford Edsel automobile. It is probably fair to say that abstinence is the Edsel of sex education today.

The notion of tailoring sex education curricula to specific consumer groups can take numerous forms. It can address the literacy level of the target groups. For example, in urban high schools where many students read at perhaps a fourth grade level, low-literacy materials could be made a part of the program. The curricula can also address specific ethnic groups. Ethnic groups in the United States differ on how sex and sex education is viewed, but an awareness of these differences and how to address them is notably missing from the sex education literature. Tailoring curricula to accommodate the different attitudes and perspectives existing within different ethnic cultures could result in enhanced program effectiveness. At present, only minimal steps have been made toward providing comprehensive sets of curricular materials in Spanish, for example. Virtually all of these are simply direct translations of the English materials. Little or no attention is paid to the specific values of the Hispanic community. Materials in Asian languages with appropriate adaptations for cultural diversity should be developed for teen programs in communities (e.g., on the West Coast) where these languages are often spoken in preference to English.

The central tenet of the argument made here is that the cognitive state and the perceived needs of the target consumer group must be

given high priority in any social action program designed to influence attitudes and behavior. The success of such an approach in the area of smoking prevention has been addressed. A similar argument has been made elsewhere with regard to adolescent nutrition (Amos, Pingree, Ashbrook, Betts, Fox, Newell, Ries, Terry, Tinsley, Voichick, & Athens, 1989). The specific recommendations presented here for sex education curricula are:

1. *Start with the perceived needs and interests of the children who are the target of the program.* Any program that ignores the concerns of the students is likely to fail. Taking the students' perspective seriously will increase the probability of success.
2. *Emphasize the short-term, concrete aspects of teenage sexual behavior and its consequences.* Pregnancy and AIDS are remote abstractions for many teens. These concepts can be made more concrete by using such techniques as role playing and discussions with parenting teens.
3. *Adapt the program to the ethnic makeup of students.* The curriculum stands a better chance of succeeding if it addresses the needs, values, and norms of ethnic groups receiving the training.

To conclude, the ideas presented here are not meant to be a panacea for a frustrating social problem. And no pretensions are made that all of the ideas are completely new to the construction of sex education curricula (cf., Urberg, 1982). Rather, the intent has been to suggest a different direction—one that uses the abilities and the perceived needs of adolescents as the basis for curriculum design. Much of the success of free enterprise rests on the marketing approach that has been described. It is just possible that the same approach is relevant to the area of adolescent sex education.

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