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Eva Goldfarb

Norman A. Constantine

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SEXUALITY EDUCATION

Eva S. Goldfarb

Department of Health and Nutrition Sciences

College of Education and Human Services

Montclair State University, Montclair, NJ

goldfarbe@mail.montclair.edu

Norman A. Constantine

Center for Research on Adolescent Health and Development,

Public Health Institute, Oakland, CA, and

School of Public Health, University of California, Berkeley, CA

nconstantine@berkeley.edu

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Synopsis

Sexuality education comprises the lifelong intentional processes by which people learn about themselves and others as sexual, gendered beings from biological, psychological and socio-cultural perspectives. It takes place through a potentially wide range of programs and activities in schools, community settings, religious centers, as well as informally within families, among peers, and through electronic and other media. Sexuality education for adolescents occurs in the context of the biological, cognitive, and social-emotional developmental progressions and issues of adolescence. Formal sexuality education falls into two main categories: behavior change approaches, which are represented by abstinence-only and abstinence-plus models, and healthy sexual development approaches, represented by comprehensive sexuality education models. Evaluations of program effectiveness, largely based on the outcomes of behavior change models, provide strong evidence that abstinence-only programs are ineffective, and mixed evidence on the effectiveness of programs that include contraception and safer sex. There is a particularly strong need for sexuality education among traditionally underserved youth, including sexual minorities, youth with disabilities, and those in foster care.

Keywords: (abstinence, communication, culture, education, family, health, identity, parent, pregnancy, relationships, rights, school, sex, sexuality, values)

Glossary

Comprehensive Sexuality Education: Teaching emphasizing a broad, holistic, and positive view of healthy sexuality, that employs a health promotion and human development approach. CSE recognizes sexuality as a life-long human force and as a potential source of pleasure, which needs to be understood and appreciated for better mental, physical, social and spiritual health.

Sex: 1. The behavioral manifestations of sexual urges, instincts and desires. 2. One's biological makeup, which is typically denoted as male or female and can include intersex.

Sex Education: Teaching the basics about sexual anatomy and about prevention of pregnancy and sexually transmitted diseases. Includes abstinence-only and abstinence-plus approaches.

Sexual Communication: Deliberate discussions about sexuality related issues as a means of transmitting information, values, beliefs and skills. Frequent, positive parent-child communication about sexuality can support sexual health in young people, but rarely occurs due to discomfort and fear.

Sexual Socialization: Informal process, beginning in infancy, by which individuals learn skills, attitudes, values, ideas and patterns of behavior related to sexuality through their life experience. The family is a primary source of sexual socialization through both explicit and implicit messages and modeling.

Sexuality: Sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its various dimensions involve the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships.

Sexuality Education: the lifelong intentional processes by which people learn about themselves and others as sexual, gendered beings from biological, psychological and socio-cultural perspectives.

Introduction

Sexuality education comprises the lifelong intentional processes by which people learn about themselves and others as sexual, gendered beings from biological, psychological and socio-cultural perspectives. It takes place through a potentially wide range of formal and informal programs and activities. Although sexuality education can and should occur throughout the lifespan, the main focus of most formal sexuality education programs worldwide is on adolescents. The areas covered by sexuality education fall across a broad spectrum including gender and gender identity, sexual orientation, relationships, anatomy, sexual behavior, reproductive functioning and options, disease and pregnancy prevention, human interaction, and more. Sexuality education exists, arguably, in every country and culture. The form that it takes and how it is identified, however, vary greatly. Historically, sexuality education has been referred to as sex education, family life or family living education, comprehensive sexuality education, or relationship education reflecting the evolving and often disparate philosophical, political, and programmatic approaches to the field. It is offered in schools, community settings, and faith-based or religious centers. Informal sexuality education also takes place within the family, among peers, on the internet, and within a culture's various other media.

Developmental Foundations

All sexuality education for adolescents takes place within the context of a fundamental set of developmental progressions involving biological, cognitive, and social-emotional changes. Biologically, puberty entails changes in appearance, sexual drive, and reproductive potential, and strongly affects psychological development as well as social and familial relations. Cognitive development during adolescence results in increasingly sophisticated ways of thinking. Social-

emotional development corresponds with changes in rights, privileges, and responsibilities concurrent with the assumption of new roles and engagement in new types of relationships, together with increasing expectations to regulate one's emotions, particularly in response to social context. Factors in the social environments of family, peers, educational systems, religious institutions, and the larger society interact with and help shape the biological, cognitive, and social-emotional progressions of adolescence.

At the same time, adolescents must deal with a variety of psychosocial developmental tasks as part of the normal processes of healthy development. These include self-discovery and self-understanding (identity), establishing a sense of independence (autonomy), developing competence (achievement), and forming close relationships with others (intimacy). Overlapping with these four issues is another—developing a sexual identity (sexuality). This essential developmental task involves dealing with new feelings of sexual interest and desire, as well as developing sexual knowledge, beliefs, values, and behaviors. Sexual orientation generally emerges during adolescence, sometimes involving uncertainty, and especially for sexual minority adolescents, potential confusion. And as gender values, roles, and expectations continue to develop and to be reinforced, gender identification is further solidified.

Intertwined with these psychosocial issues is another fundamental aspect of adolescence — the developmental necessity of experimentation and risk taking. Risk taking comes in many forms, sometimes but not necessarily exposing the adolescent to potential harm. Risk taking need not -- and cannot -- be eliminated, only potentially redirected.

Any attempt to influence adolescents' sexual health and development will be embedded within the complex multidimensional contexts of their developmental needs, processes, issues, and influences. For example, as adolescents experience an increased need to demonstrate

autonomy and independence, reactance theory in particular and basic principles of adolescent development in general highlight the limited potential of didactic approaches that attempt to impose adult values and behavioral standards on youth. According to reactance theory, when people feel that their freedom to choose an action is threatened, they experience reactance, i.e., enhanced motivation to perform the threatened behavior, thus proving that their free will has not been compromised. This theory identifies adolescence as a time of heightened reactance. Similarly, as adolescent thinking becomes more nuanced and critical, an opportunity is missed when sexuality education focuses too heavily on implanting facts, skills, and messages representing adult values and beliefs. Adolescents' increasing need for respect and competence validation can further undermine efforts that ignore their developing cognitive and emotional sophistication.

In general, programs and curricula that focus on behavior change – in other words, preventing risky behavior -- view adolescents as rational decision makers motivated to maximize positive outcomes. Other factors such as health beliefs, social norms, and perceived self-efficacy are sometimes included, but decision making is typically viewed from a rational, deliberative, and intentional perspective. Yet cognitive and social psychological research has for some time demonstrated how judgment and decision making are much more complex. We now know that decision making involves significant social and emotional influences as well as necessary cognitive shortcuts, and it is subject to an assortment of well documented biases and self-deceptions. A growing number of “dual-processing” theories address the interacting influences of two distinct cognitive processing systems. The first is viewed as an intuitive, quick, automatic, effortless, reactive, and often emotionally charged system that is governed by habit and difficult to control, while the second is seen as a slower, effortful, logical, and intentional system that can be easier to control but is limited by the cognitive and attentional demands it

creates. These approaches have more recently been applied to adolescent decision making. Examples include models that emphasize behavioral willingness over behavioral intentions, and those that focus on gist-based intuitive decision making over rationally-derived deliberative decision making. Also in this vein is a growing body of brain systems research on the risk behavior implications of developmental interactions between adolescents' later maturing cognitive control systems and their earlier maturing social and emotional reward-seeking systems.

A thorough understanding and incorporation of the principles and issues of adolescent biological, cognitive, and social-emotional development can provide the critical foundation necessary for sexuality education to meet its full potential. This is perhaps the biggest challenge in designing and delivering effective sexuality education, a challenge that is often neglected.

Sex and Sexuality

The types of education about sexuality that people experience throughout life depend on several factors including their culture, religion, and gender, as well as where they live. The particular impetus and philosophical rationale for offering sexuality education further affects what gets taught as well as how and to whom it gets taught. Although “sex education,” “sexuality education,” and “comprehensive sexuality education” are often used interchangeably, they actually signify different approaches to education.

The term “sex” has two common definitions: the first is a set of behaviors that includes sexual intercourse (and may or may not include oral and anal sex as well as other sexual behaviors). The second definition refers to one's biological makeup, which is typically male or female. To many, the term “sex education,” therefore, connotes teaching the basics about sexual

“plumbing,” and about prevention of pregnancy and sexually transmitted diseases that can result from various sexual behaviors. The term “sex education” can wrongly imply to some that children will be taught “how to have sex” and can lead to concern about the value as well as the potential harm that such education represents.

“Sexuality” on the other hand is a broader term that includes “sex” as part of its definition, but also covers the many aspects of being a sexual person. According to the Sexuality Information and Education Council of the United States (SIECUS), “Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its various dimensions involve the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships.” As such, the term “sexuality education” is generally preferred by professionals and educators as a more inclusive description of the spectrum of topics likely to be covered in educational programs in this area. The term “sex education,” however, is still often used by many as an equivalent term, which may cause confusion about the field among parents, students and the public.

Sexuality education in all of its forms can be seen as a reflection of a culture’s, community’s, or family’s values and belief systems regarding gender and sexual norms, and the appropriate role of sexuality in people’s lives. Historically there have been two approaches to education about sexuality which, while often grouped together, have had very different goals and purposes and have reflected dissimilar assumptions about the function of sexuality and sexual behavior in humans. One approach, which fits the philosophy connoted by the label “sex education,” sees sexuality as a natural but potentially dangerous force that must be controlled, and expressed only in certain appropriate manners, times and circumstances. This approach focuses primarily on behavior change. The other approach, consistent with the label

“comprehensive sexuality education,” is based on a broader and positive view of sexuality. It focuses on healthy sexual behavior as one aspect of overall health and development.

Essential Components of Sexual Health: A Foundation for Comprehensive Sexuality Education

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

(U.S. Centers for Disease Control and Prevention definition based on World Health Organization working definition, 2002)

To many people, the term “sexual health” implies freedom from sexually transmitted diseases, sexual and reproductive health issues such as cervical or prostate cancer, and avoidance of unintended pregnancy. From the perspective of such national and internationally recognized health organizations such as The Centers for Disease Control and Prevention (CDC), the World Association of Sexual Health (WAS), the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF), however, the concept of sexual health, as with health in general, includes not only the absence of disease but also the presence of positive characteristics. These characteristics enable a person to experience and express his or her sexuality throughout life in ways that are consistent with his or her personal values and beliefs, without undue barriers or hardship. What sexual health looks like, and how a person expresses or experiences his or her sexuality, will certainly change over the course of a person’s life. But a common set of attributes and skills -- the ability to think critically, to make good decisions that support one’s physical, emotional and mental health, to enter into and maintain healthy

relationships with others, and to appreciate one's own body and sexuality – form the foundation of sexual health.

Circles of Sexuality

One model that demonstrates the holistic and multifaceted nature of human sexuality, and has often been cited as a framework for comprehensive sexuality education, is the Circles of Sexuality, developed by Dennis Dailey and adapted here (Figure 1). This model identifies five facets of human experience that overlap and combine to create the totality of a person's whole sexuality. These circles, represented in the figure, include Sensuality, Intimacy, Sexual Identity, Sexual Health and Reproduction, and Sexualization. Healthy sexuality involves all five circles of the model. The overlap of the circles indicates that a problem in one circle will have an impact on the other circles as well, and the overall sexual health of the individual will be affected. Comprehensive sexuality education addresses all five of the model's circles in its treatment of various sexuality-related topics.

<Figure 1 near here>

SIECUS Guidelines: A sexually healthy adult

In the early 1990's, SIECUS convened a National Guidelines Task Force for Comprehensive Sexuality Education consisting of leading educators, health professionals, and adolescent development experts. Their work resulted in the publication of a set of guidelines for comprehensive sexuality education (see Table). These Guidelines have been adapted for Latino communities in the United States, as well as for several other countries. Building on the Circles

of Sexuality model, the Guidelines provide the basis for comprehensive sexuality education by identifying and detailing six essential and developmentally appropriate areas of learning about sexuality that young people should experience at each grade level from Kindergarten through 12th grade.

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International Planned Parenthood Federation (IPPF) Framework

Also building on the framework presented by the Circles of Sexuality model, and following the lead of the SIECUS Guidelines, several efforts have been made internationally to define high-quality comprehensive sexuality education. The newest and most influential paradigm to emerge ties sexual health to sexual and reproductive rights, focusing especially on issues of gender equity and the development of critical thinking. The International Planned Parenthood Federation (IPPF) articulates the newest consensus on comprehensive sexuality education and its approach to holistic sexuality.

A rights-based approach to comprehensive sexuality education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views ‘sexuality’ holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.

(IPPF Framework for Comprehensive Sexuality Education, 2010)

In its Framework for Comprehensive Sexuality Education, the IPPF delineates seven essential components that all comprehensive programs should include. Six of these are gender, sexual and reproductive health, sexual rights and citizenship (knowledge of and active participation and advocacy around international human rights, policies and cultural norms),

violence, diversity, and relationships. The seventh component -- which is not new within the model for comprehensive sexuality education but which continues to be the most controversial -- is that of pleasure. Just how taboo this aspect of sexuality education remains becomes clear in the struggle to include the concept of pleasure in many of the most popular programs worldwide. While it is relatively easy to gain consensus about the need to reduce unintended pregnancy and disease, encouraging positive attitudes, values, and experiences in the sexual realm, and in particular placing a value on pleasure, continues to be a lightning rod for criticism by opponents of comprehensive sexuality education.

School-Based Sex and Sexuality Education

The wide variety of school-based (and community-based) sex and sexuality education can be categorized according to fundamental distinctions in goals, purposes, and assumptions. The first type, sex education, focuses on behavior change. The second type, comprehensive sexuality education, focuses on health promotion and optimal human development, with healthy sexual behavior viewed as one aspect of overall health and development.

Behavior change approaches: sex education

Two primary models comprise the behavior change approach. The first model, which aims to uphold a particular sexual morality by promoting sexual restraint, was popular in the late nineteenth and early 20th centuries. It experienced a resurgence beginning in the 1980s in the form of abstinence-only education, sometimes referred to as abstinence-only-until-marriage education. In their most recent form, these programs state their exclusive purpose as teaching the social, psychological, and health gains to be realized by abstaining from sexual activity, and,

among other things, teach that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity. These programs tend to be concerned with religious-based values and use such terms as “chastity,” “virginity,” “purity,” and “the sanctity of marriage.” They exclude instruction about contraception, condoms (except to note failure rates), safer sex, abortion and other related topics.

The second and most common model aims to decrease pregnancy and sexually transmitted disease (STD) rates by using a disease prevention or harm reduction approach to reduce sexual behaviors that can put a person at risk for pregnancy or disease. Pregnancy and disease-prevention programs are often referred to as abstinence-based or abstinence-plus programs because they encourage abstinence while also providing information and instruction about contraception and other protection. Often these programs are wrongly referred to as comprehensive sexuality education because of their inclusion of contraception. Yet true comprehensive sexuality education goes beyond the inclusion of condoms and contraception.

Reliable population-based data on the proportions of adolescents receiving sex education are largely unavailable. One exception involves the National Survey of Family Growth (NSFG) in the United States. Nationally representative data from the 2006-2008 NSFG show that 96% of females and 97% of males aged 15-19 reported receiving some type of formal sex education. Yet 30% of females and 38% of males adolescents said that they did not receive instruction on methods of birth control. These data reinforce findings from another national survey in the United States, by the Kaiser Family Foundation in the year 2000. This study estimated that 89% of the nation’s secondary school students received some type of sex education in school, while only 68% received information about how to use condoms correctly. About half of the surveyed students reported that they wanted to know more about HIV, STDs, what to do in cases of rape

or sexual assault, how to deal with emotional consequences of being sexually active, how to talk to a partner about birth control and STDs, and how to use and where to get birth control.

Healthy sexual development approaches: comprehensive sexuality education

Comprehensive sexuality education (CSE) is based on a broader and more positive view of healthy sexuality, employing a health promotion and human development approach. Comprehensive sexuality education recognizes sexuality as a life-long human force and as a potential source of pleasure, which needs to be understood and appreciated for better mental, physical, social and spiritual health. Comprehensive sexuality education programs attempt to build upon a thorough understanding of the developmental aspects and contexts of adolescence. They address a range of issues, including growth and development, gender roles and stereotypes, sexual orientation and identity, critical thinking, media literacy, sexuality across the lifespan, prevention and treatment of sexual health problems, love, sexual attraction, sexual pleasure, communication, relationship skills, parenting, and sexual and reproductive rights. The Netherlands, Sweden, and other Western European nations have led the way in this type of sexuality education, while in some developing countries sexuality education is moving in this direction as well. Examples of current approaches to comprehensive sexuality education include gender-sensitive rights and responsibilities approaches such as *It's All One: Curriculum Guidelines and Activities*, developed by the International Sexuality and HIV Curriculum Working Group and distributed by the Population Council; positive sexuality curricula such as the Unitarian-Universalist Association and United Church Board's *Our Whole Lives*; and multi-component youth development interventions such as the Children's Aid Society's *Carrera Adolescent Pregnancy Prevention Program*.

Most mainstream school and community programs in use today are designed from a disease prevention sex education model. This is largely due to the major sources of funding available, which support this kind of approach and represent the current limited focus on behavior change, especially in the United States. Internationally, however, the field of sexuality education is increasingly moving toward the second model, with a focus on healthy sexual development as part of the larger context of community health, and with special attention to issues of gender equity and sexual and reproductive health and rights.

Cultural Considerations

Culture can be described as the shared beliefs, values, attitudes, experiences, and customs of a particular group, institution, or organization. Communities may share the common bond of race, ethnicity, or nationality, but there are many other aspects of culture to be considered such as language, traditions, religion, norms, gender roles, immigration status, family structure, health beliefs, and political power. Cultures are also formed around age (“youth culture”), sexual orientation and identity, geography (“urban culture”) as well as other characteristics that give a group of people a shared experience or set of values.

Cultural context and background affect how individuals receive and interpret messages about sexuality. Research has shown that if learners do not feel that their group or culture is specifically addressed in a program, they are less likely to internalize its messages. For this reason, programs that might be effective with one population often do not enjoy similar success with a group from a different culture, gender, sexual orientation, identity, etc., and programs tend not to translate well internationally. These findings make cultural considerations paramount in the design, implementation, and evaluation of sexuality education programs. Increasingly,

programs that seek to influence sexual development or alter sexual behaviors of young people are being designed with specific intended groups as their focus.

Complicating matters is the fact that a person may identify with more than one cultural group at a time. For example, a Catholic Latina lesbian adolescent might identify with the cultural values and mores of her ethnic group as well as that of her religion, sexual orientation, and age. The conflicting messages and values she may get from each may cause confusion for her and affect what and how she will learn about sexuality.

Findings about impact of a teacher's gender, race, ethnicity, perceived socio-economic status, religion, etc. on student learning and outcomes have been unclear. In some qualitative studies students have reported that they are less able to relate to a teacher discussing sexual decision-making and values if they perceive that the teacher does not share their culture. These findings are suggestive, however, there is not sufficient evidence to draw specific conclusions about which teacher characteristics might have more or less of an impact on student learning than others. Cultural issues can play an important role in how individuals make decisions that affect their sexual health, and they may need to be addressed or at least understood when planning a comprehensive sexuality education program. To create a program that will be effective and meet the needs of its intended audience, planners need to know such simple things as what dialect the target group speaks, as well as which expressions or gestures are commonly used and accepted. They also need to be aware of other cultural communication issues that might be harder to recognize, such as issues of whether eye contact is viewed as polite or rude or if emotions are freely expressed.

In addition, programs should reflect the target audience's styles of communication, structures, roles, and expectations of family relationships, attitudes toward intimacy, sexual

orientation, identity, and behavior at different ages and stages in a relationship, beliefs about gender roles, and beliefs about the roles of spirituality and religion. To do this, it is important for program planners to include the community they wish to serve in the planning and implementation of the educational program. Youth, parents, and community and religious leaders can all provide valuable insight into their community's specific characteristics, values, and beliefs, which can affect how their youth will interpret messages and learn about sexuality.

Not all cultural values and customs need to be equally valued and respected, especially in cases where they cause harm, violate human and sexual rights, or directly contradict the goals and values of sexuality education. In such cases, comprehensive sexuality education programs can help to raise the consciousness of a community or a new generation of young people by putting the values and customs in the context of the values of sexuality education : access to information, access to services, the ability to make informed decisions about one's own sexual health and well being, and respect for gender and human rights. As above, however, it should be done in consultation with and guidance from members of the culture or community itself. Efforts seen as coming from agencies or educators outside of the culture may be viewed as insensitive and culturally imperialistic.

Teacher Training

One of the most critical factors in the success of any sexuality education program is the teacher or facilitator. Yet training for sexuality educators is not consistent or regular. The vast majority of pre-service teaching programs do not include requirements in sexuality education. Further, while ongoing professional development is a requirement in any field, few national or other jurisdictions require any special training or ongoing certification in sexuality education. As

a result, teachers at all grade levels typically lack critical skills and feel unprepared and uncomfortable teaching about this topic, although many are required to teach it nonetheless. Many comprehensive sexuality education programs provide specialized training for teachers or facilitators of their programs, but in situations where teaching about sexuality is only one small aspect of their work, teachers are often provided little or no formal training or education in this area.

Many school districts opt to outsource, in whole or part, their sexuality education to community-based organizations that focus on sexual health issues. The advantage of this approach is that the community-based educators, in theory, are all trained, comfortable and competent in delivering sexuality-related content, and more likely to stay abreast of current trends and best practices. A disadvantage of this approach is that outsiders will not have the personal connections, relationships, and rapport with students that teachers sometimes enjoy.

Policy and evidence

Local, state, and national sexuality education policies around the world frequently comprise patchworks of mandates, funding restrictions, omissions, and compromises, often at odds from one level to the next. As a result, the school-based sex and sexuality education received by most students is fragmented, incomplete, and frequently based on ineffective approaches and curricula. Much of this policy chaos arises out of politically fueled and morally motivated debates over the appropriateness of different approaches to sexuality education. Although often rancorous and emotionally charged, these debates typically invoke research-based evidence.

In any discussion of program effectiveness evidence, the choice of primary outcomes is critical. A principal interest in behavior-change outcomes in this field dominates the research on program effectiveness as it does program development. Evaluations, many of which have been conducted in the United States, have been overwhelmingly focused on whether programs reduce sexual activity and increase contraception use and other harm reduction behaviors. Notably missing from this body of research are measures of positive sexuality characteristics, for example, ability to enter into and maintain healthy relationships, strong communication skills (beyond just refusing unwanted sex), experiencing positive sexual and romantic relationships, asserting one's sexual rights and respecting the rights of others.

The largest and most rigorous effectiveness study to date was a congressionally mandated five-year randomized trial of the US Title V, Section 510 Abstinence Education Program. This trial, conducted by Mathematica Policy Research, tested four of the most promising available abstinence-only programs. The results showed no significant differences between randomly assigned program participants and no-intervention control students on the primary outcomes of number of sexual partners, expectations to abstain, and reported rates of pregnancy, births, and STDs. These results were reinforced by another large-scale study, an epidemiological analysis employing the National Survey of Family Growth, which also found no differences in teen pregnancy rates among adolescents who reported having received abstinence-only education, versus those who received no sex education. Although either study alone provides convincing evidence, their consistent results across different methodological approaches by different research groups and with different samples provide strong evidence of the ineffectiveness of abstinence-only approaches.

The NSFG analysis also provided evidence of positive behavioral effects across abstinence-plus curricula. Adolescents who reported receiving abstinence-plus sex education had half the risk of teen pregnancy compared to those who reported abstinence-only education and 40% of the risk compared to those who reported no sex education.

Studies to test the effectiveness of specific abstinence-plus sex education programs have yielded less compelling evidence. There is no shortage of suggestions of positive effects from the numerous evaluations that have been conducted of promising programs. Most of these evaluations, however, have taken place at the local school district or community level, and suffer any number of the usual flaws and biases commonly associated with school and community evaluations: pre-existing group differences or control group contamination, differential post-randomization attrition, uncorrected multiple significance testing, and selective reporting of results, to name a few. Some narrative reviews have concluded that the evidence indicates effectiveness for the best of these programs, and some have even created lists of recommended “evidence-based” programs and strategies. But the more rigorous research syntheses based on meta-analytic methods have been more cautious in drawing conclusions. The two gold-standard meta-analyses conducted in this area, those sanctioned by the primary international research review bodies in social and educational interventions (the Campbell Collaboration) and health and medical interventions (the Cochrane Collaboration) each independently concluded that the evidence of effectiveness for abstinence-plus programs in lowering rates of sexual initiation and pregnancy risk was inconsistent. In addition, the Campbell authors concluded that the evidence of effectiveness on reducing unintended pregnancy also was inconsistent, while the Cochrane authors found this evidence to slightly favor small pregnancy reduction effects. Both reports noted the dearth of rigorous evidence on program effectiveness.

These mixed findings, based on syntheses of multiple individual evaluations of abstinence-plus programs, seem to contradict the readily available lists of “Programs that Work” and “Science-Based Programs” compiled and publicized by national policy and advocacy groups, and even by the U.S. federal government. In general, these lists are based on some variation of the “one study/one outcome rule.” In other words, if one evaluation that meets certain minimal methodological criteria can be found with at least one behavioral outcome showing a statistically significant positive effect, the program earns a place on the list. But this approach and the “evidence-based” labels that result amount to little more than institutionalized selective reporting. The problem with this approach is illustrated by the recently developed list of approved programs for US Department of Health and Human Services Teen Pregnancy Prevention funding eligibility. Twenty-eight programs were certified as evidence-based. However, according to the Coalition for Evidence-Based Policy, an independent research-use watchdog group, “HHS's evidence-based teen pregnancy prevention (funding) program is an excellent first step, but only 2 of 28 approved models have strong evidence of effectiveness.”

The most compelling adolescent sexual health outcomes have been found in Western Europe, where comprehensive sexuality education generally enjoys widespread support and is typically accompanied by reinforcement of positive sexuality-related messages within families, as well as broad access to reliable contraception and youth-friendly sexual and reproductive health services. Teen birth rates in Western European countries typically range from one tenth to one quarter the magnitude of rates in the United States. While it is difficult to separate out the effects of the many cultural and policy differences across countries, sexuality education is widely regarded as one important factor in explaining these substantial differences.

Parent and public support

There have been few studies that have tried to assess parental and public support for school-based sexuality education around the world. Qualitative data from Western Europe show strong support among parents, policy-makers and the public at large for comprehensive sexuality education in the schools. In the U.S., a variety of state and national representative sample surveys have addressed the issue of parent and public support for different approaches to sexuality education. These surveys typically ask about preference for one or the other of the two types of behavior change approaches, abstinence-only versus abstinence-plus teaching about contraception and protection, with definitions of each type provided to the respondents. Consistent widespread support for the abstinence-plus approach has been found across parents and the general public nationally and within states of varying geographic and demographic characteristics, and across specific subgroups based on age, race, ethnicity, religion, education, political ideology, and income. Although surveys generally have not asked about the more expansive components of comprehensive sexuality education (even when using that term in their questions), majorities of respondents have been found to support including information about relationships, sexual decision making, parenting, and sexual orientation.

Sexuality Education in the Family

Sexual socialization versus sexuality education

Socialization is a process by which individuals learn skills, attitudes, values, ideas and patterns of behavior and is largely achieved through life experience. The sexual socialization of children begins during infancy and continues up to adulthood. The family is a primary source of sexual socialization as parents transmit and model their values, beliefs and practices related to

sexuality, both positive and negative. For example, the types of toys that parents give to young children, the ways in which they decorate a baby's or child's bedroom, and the types of activities they encourage their children to try (whether sports, music, theater, art, etc.) teach the child about the parents' views on gender and gender roles. From a very young age, children are exposed to messages about sexuality, including, privacy, nudity, masturbation, power, and equality, as well as appropriate expressions of emotions such as affection and love. As they get older, they also learn their parents' views on such things as sexual behaviors within and outside of marriage, abortion, and gay rights. Parents teach their children about their sexual values, beliefs and behaviors through both explicit and implicit messages and modeling, intentionally or not. The sexual socialization that occurs in the family is one of the strongest influences on the developing child and the sexual adult he or she becomes.

The process of sexual socialization is not the same as sexuality education. Education is an intentional planned process of transmitting knowledge, skills, and values. There is a well-known and often stated sentiment that parents are the primary sexuality educators of their children. While philosophically this may be an important message, in fact, research suggests that most parents do not feel well prepared to have specific, deliberate conversations with their children about sexuality. In other words, while they remain a very important source of sexual values and beliefs, parents and guardians are not necessarily the primary sexuality educators of their children. That role falls largely to the informal sexuality education provided by peers and the media, and formal sexuality education in schools, religious institutions, and other organizations. This becomes increasingly the case as children grow into their adolescent and young adult years when, as part of normal adolescent development, outside sources take on increasingly important roles in their lives and the influence of the family diminishes.

Parent communication

In parts of Western Europe, families routinely have open and frank discussions about adolescent sexuality. In The Netherlands, France, and Germany, for example, studies have found that parents commonly and openly discuss sexuality with their children from an early age and are likely to include discussions of the positive and pleasurable aspects of sexuality. These countries, however, represent the exception when it comes to findings about parent-child communication about sexuality.

Although many studies indicate that adolescents say they would like their parents to talk with them about sexuality, a large body of research has consistently found that parent-child communication about sexuality is often fraught with difficulty and discomfort.

Many parents do not feel comfortable or adequately prepared to discuss sensitive topics with their children. They are sometimes fearful of the embarrassment such a conversation might cause for their children and themselves, or hesitant about being seen as prying into their children's lives. They often doubt that they have enough expertise on many topics to adequately teach their children and can be fearful of being asked questions they cannot answer. Fathers tend to report more challenges and are less likely to communicate with their children about sexuality, particularly their daughters. Numerous studies also suggest that many adolescents are not comfortable talking with their parents about sexuality either. Substantial proportions of teens report little or no direct communication about sexuality with their parents, and most teens and parents are dissatisfied with some aspects of their communication about sexuality.

Studies that have examined the impact of parent-child communication about sexuality on the child's sexual risk taking have yielded mixed results. If communication starts early, and

especially before the initiation of sexual intercourse, and if there is a close parent-child relationship, then parent-child communication may delay the child's initiation of sexual intercourse and may increase condom use when the child does have sexual intercourse.

Research suggests that the type of communication is as important as the amount in the impact it has on children. Teenagers in the United States report that most of the discussions their parents have with them are about the dangers and risks of having sexual intercourse and about discouraging them from being sexually active. Although systematic research has been limited, some other parts of the world appear to be similar to the United States in the type of communication about sexuality that goes on between parents and children.

Parent education and support interventions

Because the critical role that parents play in the healthy sexual development of their children is widely recognized, programs have been developed to support parents in their efforts to communicate with their children about sexuality. Most of these programs have had one or more of the following objectives toward that goal: increase parents' knowledge, help parents to clarify the values they wish to convey to their children, improve parents' skills in talking about sexuality, increase parents' comfort talking about sexuality while acknowledging that it is natural and acceptable to feel uncomfortable, and provide structured opportunities for young people and their parents to talk together about sexuality-related topics. Programs have been implemented through a wide array of venues including community and faith organizations, places of employment, and children's schools as well as institutions of higher education, and have ranged from one-shot to multi-session programs as well as ongoing community events. The targeted audiences have been parents only, youth only, or parents and their children together. Finally, the

forms they have taken have included full course curricula, homework assignments within adolescents' programs, instructional videos, newsletters, pamphlets, guides for parents, media campaigns such as public service announcements, billboards and postcards, and grassroots community organizing. In addition, there are many websites dedicated to helping parents improve their communication skills around sexuality with their children and adolescents.

Research suggests that some programs do increase parent-child communication about sexuality, although the increases may be short-lived. The programs that are most successful are those that involve parents and their children communicating together and those that are more intensive and longer in duration. A minority of programs have shown a measured impact on parents' knowledge, clarity of values, skills, or comfort

An especially promising approach to improving parent-child communication about sexuality and its impact is found in programs that focus not only on increasing parent-child communication, but also on other ways in which parents can influence the optimal development of their children. This includes efforts to help parents become more connected with their children, supervise and monitor them more appropriately, model responsible sexual behavior, and respond appropriately to possible sexual behavior and pregnancy among their children, including older siblings of the adolescent.

Although research results on the effects of parental communication on their children's sexual behavior and sexual risk have been mixed, few studies have examined the impact of parental communication on children's overall sexual health, including the positive sexuality attributes emphasized by comprehensive sexuality education.

Meeting the needs of Underserved Youth

One of the great challenges for sexuality education is reaching populations that are traditionally underserved. Three such groups -- sexual minority youth including those who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ), students with disabilities, and foster youth--have special needs in this area.

Sexual Minority Youth

Numerous studies have documented that LGBTQ youth, and those perceived to be LGBTQ, are likely to face frequent bullying, harassment, or assault in school. Anti-gay slurs often go unchallenged by students, teachers, and administrators. LGBTQ students report feeling unsafe in schools and are much more likely than their heterosexual peers to skip school because of safety concerns. They are at greater risk for alcohol and drug abuse, and suicide. At the same time, sexual minority youth and issues of sexual orientation, gender identity, and homophobia tend to be minimally addressed in the sexuality education classroom.

Despite numerous surveys that report general support among parents and educators for the inclusion of sexual orientation and LGBTQ topics in sexuality education curricula, these topics rarely get taught. This is due, in part, to social and political pressure at the local district level and in some cases to laws or policies that prohibit the discussion of sexual orientation or gender identity in any school subject. At the same time, however, it is due to lack of knowledge and comfort among teachers about how to incorporate these issues and a general lack of understanding about what these students need.

When it comes to sexual orientation, most sexuality education programs focus on heterosexual students, discuss dating in terms of heterosexual couples, and assume heterosexuality in discussions of contraception. Studies have found that, while often

unintentional, this narrow focus has the effect of sending a message that heterosexuality is privileged and visible while other orientations are relegated to the shadows and can be ignored. These exclusions of non-heterosexual identities from the curriculum may also foster the homophobic environments that exist in many middle- and high-schools. Research has shown that girls who identify as lesbian or are unsure of their sexual orientation are more at risk of becoming pregnant and of practicing unprotected sex than their heterosexually identified counterparts. While this may seem counterintuitive, it can be explained by the homophobic environment in which many of these girls exist. Out of fear that they will be identified as lesbian, some will outwardly engage in sexual intercourse with many male partners and even become pregnant as a way of appearing as “straight” as possible. Boys who identify as gay or who are questioning their sexual orientation are likewise at increased risk for practicing unprotected sex and of causing a pregnancy.

Numerous studies have focused even greater concern on the abstinence-only-until-marriage programs which teach that sex is only appropriate within the confines of marriage. These studies point out that for LGBTQ youth who may never get married (and in most cases are legally prohibited from marriage), these messages can be particularly harmful because of they imply that there is no acceptable way for them to express their sexuality.

Examples of steps some communities and school districts have taken to become more inclusive of sexual minorities are including sexual orientation and identity in school curricula, providing in-service training for faculty and staff on sexual orientation and combating homophobia, providing education on sexual orientation and identity for parents, school boards, and community members, offering support groups for LGBTQ students, establishing gay-straight alliances or similar clubs in schools, offering counseling specifically for LGBTQ students,

establishing policies that prohibit anti-LGBTQ language and behavior, and establishing policies that prohibit discrimination in hiring and promotion of staff.

Adolescents with disabilities

Another largely underserved population with unmet needs around sexuality education comprises adolescents with disabilities. Two common and contradictory myths about people with disabilities are that they are not sexual and that they cannot control their sexuality. Research has shown that both of these misconceptions add to fear and discomfort among parents and educators about providing sexuality information and education to young people (and adults) with disabilities. Because children with disabilities are at greater risk for sexual exploitation and abuse, the inclination among those who love and take care of them often is to keep them ignorant in an attempt to protect them. Not educating these young people, however, increases rather than decreases their risk. People with disabilities are as sexual as their non-disabled peers and have the same sexual needs and the same desires for love and intimacy.

The American Academy of Pediatrics suggests that sexuality education for children with disabilities should cover body parts, the changes of puberty, personal care and hygiene, medical examinations, social skills, sexual expression, contraception strategies, and the rights and responsibilities of sexual behavior. In short, this represents much of the same instruction that children without disabilities should receive.

Foster youth

Children and adolescents in foster care are often characterized by the absence of a dependable family or social network, an intense need for affection, the desire to possess

something of their own that they do not have to share, exposure to sexual abuse, exposure to other types of violence, and limited skills in identifying and accessing resources. Additional challenges include acceptance of early pregnancy in their families of origin and by their peers, and unmet needs for love and sense of belonging. Girls may be tempted to become pregnant to hold onto a partner. At the same time, foster youth might not obtain school-based sexuality education because many school districts do not teach it, because they frequently change placement and schools, and because foster caregivers may withhold permission for their youth to participate. It is therefore not surprising that foster and formerly fostered youth are at increased risk for unintended pregnancy, HIV, and other sexually transmitted infections due to high-risk sexual behaviors such as unprotected sex and sex with multiple partners.

Several barriers stand in the way of addressing these special needs and challenges. These include unclear state and county policies about appropriate roles and potential liability for foster parents and social workers, inadequate communication between social workers and foster parents and other caregivers, inadequate training on sexuality education for social workers and foster parents, and a diversity of religious and moral beliefs and values among staff, foster parents, and group home caregivers.

All youth should have one or more trusted adults with whom to discuss sexual and other issues they face as they deal with life's increasingly complex challenges. For foster youth, there is a compelling need to help connect them to caring, committed adults who can serve in this role. In the long term, sexuality education should be interwoven with other child welfare improvement efforts to holistically address issues such as absence of trusted adults, low expectations, and the need to belong, all of which can contribute to risky sexual behaviors and pregnancy.

Conclusions

Learning about sexuality is one of the core activities of adolescence. It happens over time in both formal and informal settings, within families and among peers, through the media, and often within classrooms, religious organizations, and community agencies.

How sexuality education is defined depends largely on who is defining it. The field has undergone numerous transformations over the past century due to evolving understandings of human development, conflicting ideas about the role of sexuality in human life, and various emerging social, political and health issues that have each helped to frame the debate about the appropriate purposes and goals of sexuality education. Shifting beliefs about gender roles, advances in contraception options, the emergence and recognition of new STDs, especially HIV, advances in gay rights, and increasing scientific knowledge about sexuality including sexual orientation and identity, sexual response, and functioning have all impacted how human sexuality education is envisioned, developed, implemented, and received.

Because of competing views about the nature and purpose of sexuality education, two distinct approaches have characterized teaching adolescents about this topic. Behavior change models, represented by abstinence-only and abstinence-plus programs, emphasize the need to control sexual behavior, especially among adolescents. Recent and growing promotion of true comprehensive sexuality education models focused on promoting positive sexual health and development represent a radical shift in thinking about sexuality education. Yet evaluations of program effectiveness, as products of available funding as well as the continued emphasis on behavior-change, are still very much focused on pregnancy and disease prevention outcomes. There is a strong need for new evaluation models and measures that examine outcomes associated with positive sexual health and development defined more broadly.

This is not to say that behavioral change is unimportant. Reducing unintended pregnancies and STDs among adolescents continues to be an important goal for public health and social welfare. To that end, the most rigorous research has not been encouraging, with strong evidence that abstinence-only programs have no effect and promising but inconsistent evidence on the effectiveness of abstinence-plus programs.

The expanding vision of comprehensive sexuality education that is emerging focuses on sexual and reproductive health and rights and gender equity, and emphasizes positive sexuality as an integral component of sexual health and human development. It recognizes the importance of sexuality as a source of pleasure and general wellbeing, is built upon sound principals of adolescent biological, cognitive, and social-emotional development, and is responsive to specific cultural customs and issues. Within this emerging framework, the issues of teacher preparation and underserved youth populations continue to present important challenges that the field must surmount in its efforts to improve the sexual health and wellbeing of adolescents worldwide.

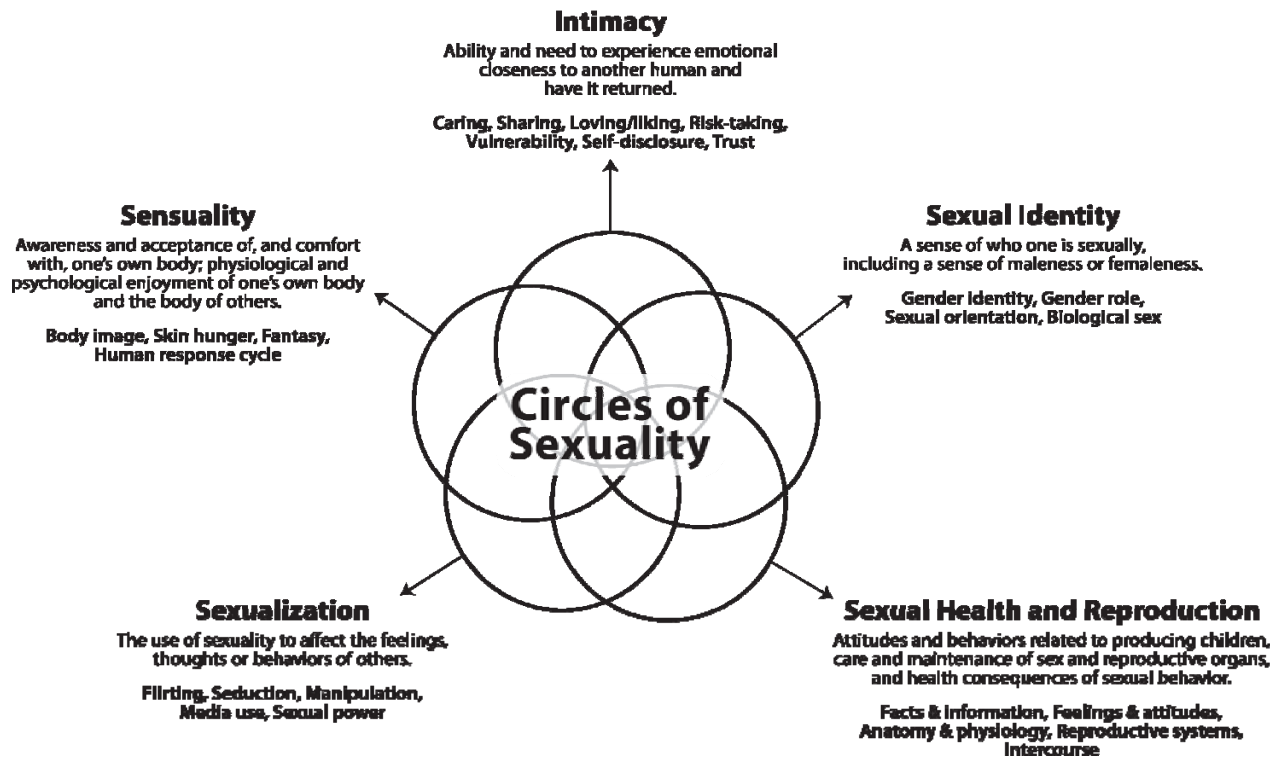
Table. Life Behaviors of a Sexually Healthy Adult

A sexually healthy adult will:

- Appreciate one's own body.
- Seek further information about reproduction as needed.
- Affirm that human development includes sexual development, which may or may not include reproduction or sexual experience.
- Interact with all genders in respectful and appropriate ways.
- Affirm one's own sexual orientation and respect the sexual orientations of others.
- Affirm one's own gender identities and respect the gender identities of others.
- Express love and intimacy in appropriate ways.
- Develop and maintain meaningful relationships.
- Avoid exploitative or manipulative relationships.
- Make informed choices about family options and relationships.
- Exhibit skills that enhance personal relationships.
- Identify and live according to one's own values.
- Take responsibility for one's own behavior.
- Practice effective decision-making.
- Develop critical-thinking skills.
- Communicate effectively with family, peers, and romantic partners.
- Enjoy and express one's sexuality throughout life.
- Express one's sexuality in ways that are congruent with one's values.
- Enjoy sexual feelings without necessarily acting on them.

National Guidelines Task Force (2004). *Guidelines for comprehensive sexuality education : Kindergarten through 12th grade*. (3rd edition). New York, NY: Sexuality Information and Education Council of the United States.

Figure 1. Circles of Sexuality



Further Reading list

Berne, L & Huberman, B (1999) *European approaches to adolescent sexual behavior & responsibility*. Washington, DC: Advocates for Youth.

Constantine, N A (2008) Converging evidence leaves policy behind: Effectiveness of and support for school-based sex education programs. *Journal of Adolescent Health, 42*: 324-326.

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Haffner, DW (1998) Facing facts: Sexual health for American adolescents. *Journal of Adolescent Health, 22*: 453-459.

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- Tepper, M (2001) *Becoming sexually able: Education to help youth with disabilities*. SIECUS Report, February/March 2001.
- Woog, D (1995) *School's out: The impact of gay and lesbian issues on America's schools*. Los Angeles, CA: Alyson Publications.

List of Relevant Websites

- Advocates for Youth: www.advocatesforyouth.org
- Alan Guttmacher Institute (AGI): www.guttmacher.org
- American School Health Association (ASHA): www.ashastd.org/
- Answer: <http://answer.rutgers.edu>
- Center for Research on Adolescent Health and Development (CRAHD): <http://crahd.phu.org/>
- Children's Aid Society, Adolescent Pregnancy Prevention program:
<http://www.childrensaidsociety.org/youthdevelopment/carrera>
- Ford Foundation Program on Sexuality and Reproductive Health and Rights:
<http://www.fordfoundation.org/issues/sexuality-and-reproductive-health-and-rights>
- Mathematica Policy Research Inc.: <http://www.mathematica-mpr.com/>
- International Planned Parenthood Federation (IPPF): www.ippf.org
- Planned Parenthood Federation of America (PPFA): www.plannedparenthood.org
- Population Council: www.popcouncil.org
- Sexuality Information and Education Council of the United States (SIECUS):
www.siecus.org
- Unitarian Universalist Association (UUA) Website on Comprehensive Sexuality Education:
<http://www.uua.org/socialjustice/issues/reproductive/comprehensivesex/>
- World Association of Sexual Health (WAS): www.worldsexology.org
- World Health Organization (WHO): www.who.int

Biographies

Eva S. Goldfarb, professor of health education and chair of the Department of Health and Nutrition Sciences at Montclair State University, is a nationally recognized expert in the field of sexuality education. Dr. Goldfarb leads sexuality education and sexual health programs with youth, parents, educators, and other professionals and has trained teachers across the country. Goldfarb is co-author of *Our Whole Lives: Sexuality Education: Grades 10-12* and *Our Whole Lives: Sexuality Education: Grades 4-6*, curricula for which she was awarded an honorary doctorate, is co-author and co-editor of *Filling the Gaps: Hard-To-Teach Topics in Human Sexuality*, and co-author of *Making Smarter Choices About Sex*, a curriculum for middle school adolescents. Recently, Goldfarb co-authored *Being Out, Staying Safe*, the first HIV/STD prevention curriculum specifically geared for Lesbian, Gay and Bisexual teens. Her work has been featured in *Sexuality and Our Faith*, on MTV.com, in *Newsweek*, *The Nation*, *Self* and *The New York Times*. Dr. Goldfarb has published numerous articles and essays and has presented at conferences worldwide in the area of sexuality education and sexual health. She holds a Ph.D. in Human Sexuality Education from the University of Pennsylvania, a Masters Degree in Communications and a Doctor of Humane Letters (honorary).

Norman A. Constantine, a research psychologist and methodologist, is program director of the Public Health Institute's Center for Research on Adolescent Health and Development. Dr. Constantine's research focuses on adolescent sexual health and rights, sexuality education, parent-adolescent communication, and policy use and misuse of research evidence. He is principal investigator of sexuality education research and policy studies funded by The California Wellness Foundation and William and Flora Hewlett Foundation and a randomized trial of the Planned Parenthood - Los Angeles Sexuality Education Initiative, and directs a

predoctoral policy research fellowship program in adolescent sexuality, health, and rights funded by the Ford Foundation. Constantine serves as clinical professor of community health and human development at the University of California, Berkeley, School of Public Health, where he teaches doctoral seminars on research methods and theory-based data analysis. He is a member of the editorial board of the Journal of Adolescent Health, and serves on the Board of Trustees for Planned Parenthood Shasta-Pacific. He helped develop and enact the 2003 California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act and the 2007 California Sexual Health Education Accountability Act, and has been widely quoted in state and national media on sexuality education research and policy.