Comprehensive versus Abstinence-Only Sex Education: What Works?
Andrea Witkin, MA, Mary Jane Rotheram-Borus, PhD, and Norweeta Milburn, PhD

The debate over abstinence-based HIV prevention, particularly for people under age 22, is complicated, making it difficult to separate political agendas from the psychology of sexual behavior. The current U.S. federal government has allocated more than $100 million toward “abstinence-only sex education.” But while there is some evidence for the positive effects of delaying “sexual debut” (the first time a person engages in sexual intercourse) and for the positive role of abstinence in the lives of young people, there is less evidence that programs offering abstinence-only messages are effective in preventing or delaying sexual behavior, pregnancy, or disease transmission. This article reviews the literature related to the role of abstinence in sexual education, particularly for young people, and offers a way of integrating abstinence alternatives into sex education without compromising other options.

Defining Abstinence

One difficulty in measuring the efficacy of sex education programs lies in the conflicting definitions of the term abstinence. For example, some studies define abstinence as totally refraining from all sexual acts outside of marriage (including masturbation) and some link it to moral or religious beliefs. Other studies define abstinence as refraining from vaginal, anal, and oral sex. By some definitions, adolescents who have experienced sexual debut can become “abstinent” by refraining from further sexual activity; but by other definitions, they cannot alternate back and forth.

Everyone involved in this debate agrees on one fact; delaying the onset of sexual debut in adolescents is a good idea, at least in theory. Indeed, abstaining from sexual activity, that is, vaginal, anal, and oral sex, is 100 percent effective as a means for preventing sexually transmitted diseases (STDs), including HIV, among both adults and adolescents. For most people, however, abstinence is a temporary goal that may reflect current life circumstances, including being a young adolescent, being between relationships, or waiting for an STD to heal. It remains effective in preventing HIV, STDs, and pregnancy only if it is applied consistently. Abstinence education seems to reflect upon an “all or nothing” ideology; in the same way that a person cannot be “a little” pregnant or partially HIV-positive, he or she cannot be sometimes abstinent.

Although most parents are not eager for their children to become sexually active, there is much disagreement about how exactly to persuade young people to wait. Sexuality Information and Education Council (SIECUS) president Tamara Kreinin has spoken out about the “health harm” of not providing correct and comprehensive information in abstinence-only programs. Many abstinence-only programs operate on a foundation of spreading “fear” and misinformation. For example, a recent review by human rights advocates of abstinence programs in Texas called one abstinence-only program a “health threat.” The review referred to the program’s message that condoms “don’t work” and its presentation of “worst-case scenarios,” both of which leave young people ill-prepared to deal with their emerging sexuality. Proponents of a more comprehensive approach to sex education argue that teaching abstinence is not enough and that young people need to know how to protect themselves if they choose to have sex. Additionally, recent polls show that parents are overwhelmingly in favor of the comprehensive approach.

In Support of Abstinence

While there are studies that have evalu-
Abstinence may be the hottest topic in HIV prevention. It raises temperatures among “personal responsibility” advocates and religious conservatives on the one hand, who believe people can and should “just say no,” and among “sex-positive” activists on the other, who believe any discussion of abstinence, even as an individual choice, is sex-negative. While the Bush administration’s “abstinence-only” funding policy is irresponsible and unjustifiable—comparable to the U.S. ban on needle exchange, which has led to thousands of deaths—the idea of choosing to abstain from sex deserves consideration.

Behind the veil of rational arguments on either side are deep historical and passionate divisions based on religious belief and the stigmatization of sexuality and sexual orientation. Adding to these schisms are more recent disagreements about the autonomy of young people and the role of school-based sex education.

We asked Andrea Witkin, Mary Jane Rotheram-Borus, and Norweeta Milburn to review the literature on “comprehensive” versus “abstinence-only” sex education, knowing that as UCLA researchers with a long history in teen HIV prevention, their beliefs would lean towards a comprehensive approach that offers abstinence as one option among many.

We also asked Christine Cipperly, a trainer for the Catholic Diocese of Sacramento, California, to talk about the role of chastity within the context of Catholic spiritual teachings, knowing that her beliefs would incline her towards abstinence-only approaches and hoping that her article would educate our readers in a thoughtful, rather than sensational, way about this perspective. My own view is that abstinence (or “chastity”) should be discussed as only one option among many in the context of a broad sex education curriculum, but I believe that what Cipperly says may need to be heard, not so much in terms of Catholic teaching, but in terms of adolescent development.

I was impressed by Cipperly’s survey of students, which found that a significant number wanted to learn more about abstinence and the skills they might use to delay sexual activity, and her concern about psychological development rather than religious structures. I was also impressed by her acknowledgment of the role of harm reduction for some teens, an acknowledgment similar to that of Witkin and her colleagues, who suggest that there is a role for abstinence-based education in the context of broader sexuality education. Neither advocates a single method, an “only” approach. Different programs might evolve with different emphases and still achieve HIV prevention and sex education goals.

One of the triumphs of HIV research has been a focus on the meaning of sexual activity in the lives of individuals. During adolescence, many of these meanings have nothing to do with physical desire, pleasure, or intimacy: at its worst, sex may become one of the requirements of a rigid, peer-based adolescent society. In response, sex education should go beyond both the mindless sex ed moments—focusing on condom and contraceptive use—that litter high school phys ed classes and the blanket and life-threatening moral judgments of fundamentalist abstinence-only programs.

At a time when there is so much pressure on educators to focus only on academic achievement, it is hard to ask them to spend time on a topic that may not boost SAT scores. But it is not just the facts and figures I learned in junior high that have helped me navigate life. It is also the skills for how to learn and how to think critically. As the focus of these lessons, many subjects, including sexual decision making, suffice.

The articles in this issue reflect what many front-line HIV providers know to be true. Individuals require personal strategies to protect them from HIV and to achieve their goals, and the role of prevention programs is to meet them where they are, whether that means supporting abstinence or safer sexual activity.

had similar sociodemographic characteristics. Researchers found that students who took the virginity pledges did delay sexual activity, but among these students, those who lapsed in their pledges and had sex were less likely than those who had not taken the pledge to use contraceptives.

Other programs such as “Not Me, Not Now,” which targeted youth between the ages of 9 and 14 in Monroe County, New York, devised a media-communicated intervention and reported that pregnancy rates of 15-to-17-year-old participants across the county decreased during the intervention period. The “Not Me, Not Now” program was designed to increase awareness of teen pregnancy and promote communication between parents and children while also encouraging abstinence. Messages were delivered via paid television announcements, billboards, posters, radio announcements, web sites, and in schools. During the intervention time period, there was a decrease in teen pregnancy in Monroe County. However, there have been no peer reviewed articles examining the effectiveness of this program or trajectory of the teen pregnancy rates after the intervention period had ended.

An additional study called “Postponing Sexual Involvement,” developed by Grady Memorial Hospital in Atlanta, was a five-session peer-taught program based on social influence theory, with an additional adult-taught component on human sexuality. The study found a reduced rate of initiation of sexual activity, but also an increased rate in contraceptive use among participants who were sexually active. When a similar study was replicated in California, however, it concluded that the program had no measurable impact on the initiation of sex.

While there are many abstinence-only based programs that may yield some positive results—that is, efficacy in delaying the sexual debut or decreasing sexual activity—there remains a lack of empirical evidence to support such programs. There is little research on the long-term value of abstinence-only programs and even less research published in peer-reviewed journals. At this point, the research reveals only that abstinence-based programs may have a short-term impact on reducing risk behaviors. Further investigation is needed to assess just what type of impact the model will yield over the long term.

Finally, recent studies suggest that psychosocial issues may predict sexual behavior among young people and undermine or facilitate the delay of sexual debut. For example, having more social support, higher socioeconomic status, caring and involved parents, and two parents in the household were all strongly associated with postponing intercourse among younger adolescents, especially females, although these factors were less important for older adolescents. In addition, emotional well-being was a significant factor in postponing sexual debut. Finally, some researchers suggest that the early onset of sexual activity may be connected to lack of parental attachment and may serve as a replacement for parental closeness and belonging.

### The Risks of Abstinence-Only Education

Although many critics of abstinence-only education agree that abstinence would be an ideal solution to the increase of new HIV infections among young people, abstinence-only education does not seem to achieve the goal of reducing unsafe sexual activity and, as noted below, may actually lead to increased risk for HIV transmission. Surveys of sexuality conclude that with or without abstinence education, most adolescents will be sexually active prior to the age of 18 and prior to marriage.

A 2002 report from the Alan Guttmacher Institute reveals that leaving teens uninformed about birth control options can have “disastrous” effects. In addition, researchers at Columbia University found that while a number of virginity pledge programs did help delay the onset of sexual activity for some teens, those who broke the pledge were less likely to use contraceptives once they became sexually active. The danger of abstinence-only education is derived when youth begin engaging in sexual activity without the knowledge of safer sex choices to guide their behaviors. Surveys conducted by the Kaiser Family Foundation found that “students who have sex education” feel better prepared and more informed to handle sexual situations than those who do not have sex education.

According to the Centers for Disease Control and Prevention, among teens aged 13 to 19, young women, especially African American women, are being infected with HIV at higher rates than young men. A recent randomized controlled study focusing on HIV risk reduction among inner-city African American adolescents examined the effects of abstinence and safer sex HIV risk reduction interventions. Abstinence intervention participants were less likely than either the safer sex intervention group or the control intervention group (which focused discussion on general health issues) to report having sexual intercourse in the three months after the intervention (but these results
disappeared at six months and 12 months). Safer sex intervention participants, however, reported significantly more consistent condom use at the three-month follow-up (66 percent) than did the abstinence group (38 percent). This trend continued at the six- and 12-month follow-ups.

Other studies have illustrated long-term positive effects on risk behaviors as a result of comprehensive sex education curricula that include an abstinence method as one option for safer behavior. For example, researchers in San Jose, California evaluated an intervention that emphasized abstinence but also discussed the benefits of condom use. They found higher rates of condom use and a reduced frequency of sex without condoms among students who participated in the intervention and they found that this effect continued for two years after the intervention.10 Similarly, among young people from families at high risk for HIV, the number of sexual partners was significantly reduced for a two-year period when parents were involved with their teens in a skills-based intervention based on a comprehensive sex education model.11

Conclusion

As the debate continues, it is important to remember that advocates for abstinence-only programs and proponents of comprehensive sex education have a common goal: the prevention of unwanted pregnancies, HIV infection, and STDs. In addition, the applicability of these different approaches may vary based on age (for example, 12 to 14 years old versus 17 to 19 years old), gender, and sexual orientation (for gay and lesbian young people, the message to wait to have sex until marriage means never having sex). Since research indicates that gay and lesbian adolescents are more likely to be separated from their families and are at an increased risk for HIV and STDs due to their lack of access to health care, comprehensive sex education is particularly important for these young people.

It is a health education adage that "one-size-fits-all" approaches are ineffective, particularly in a country whose social as well as political foundation is modeled on diversity. The lack of evidence supporting the efficacy of early abstinence-only programs has left many researchers hesitant to pursue studies or design programs that are focused in this way. Yet the issue has been politicized in ways that may undermine public health initiatives, since the federal government is pushing for abstinence-only approaches, and some states such as California are turning down federal funding for sex education because this funding is restricted to abstinence-only programs.

With half of all new HIV infections in the United States occurring among teens and young adults, comprehensive sexuality education programs become even more central to HIV prevention efforts. Researchers and advocates agree that the model should combine abstinence and safer sex approaches in a single curriculum to avoid sending inconsistent messages that might occur if these programs were separate, undermining a strong foundation for informed decision making.

A responsible choice is a well-informed choice. One alternative is for the government to fund more research on the efficacy of comprehensive sex education programs that may include abstinence as an option, research that would measure not only abstinence versus sexual activity, but also frequency of condom use and of unprotected sex. The most thorough assessment of available information may provide the tools necessary for individuals to make safer choices concerning sexual health and result in a hybrid that reflects the concerns of both sides in this polarized debate.

Clearinghouse: Abstinence and Sex Ed

References


The Argument for Chastity Education
Christine Cipperly

Is abstinence education a “Just Say No” approach to the problems and dangers of adolescent sexual behavior? Is it unrealistic to think we can empower young people to take control of their sexual behavior and their lives? Or are our youth “uneducable”?

As a health educator, I spent 10 years providing an annual HIV/AIDS Peer Educator Training for students representing all the high schools in Yolo County, a largely rural area in northern California. Every year, I was struck by the written evaluations, which consistently included comments from a significant percentage of students who wanted more information about abstinence. One year, a group of students developed an anonymous peer questionnaire. Of the 74 students, 70 responded, and of these, 30 had already had sexual intercourse. The surprise was that 15 of these 30 students said that they regretted having had sex, stating that they wished that they had waited.

Abstinence is valuable not only because it is clearly the safest method of both disease and pregnancy prevention, but also because, as this survey suggests, many youth who are or have been sexually active do not wish to continue the activity. The dilemma I faced was how to serve these students without getting caught up in the “culture wars” between abstinence-only and what is called “comprehensive” sex education.

Chastity: A Positive Virtue

In my current position working for the Catholic Church, I have helped develop a comprehensive and medically accurate sexuality curriculum for adolescents and their parents. For a variety of reasons, this approach is called “chastity education” rather than abstinence training. The most important reason is that abstinence implies a negative—the absence of sex—whereas chastity is about the clear, coherent, and consistent practice of a positive virtue: the guiding of the sexual instinct in the service of love and the integration, rather than the isolation, of sexuality in the development of the whole person.

This four-session training provides an opportunity for young people and their parents to improve communication about sexual issues, to develop standards about dating and sexual behavior together, and to form a supportive community with other parents and teens. Led by an adult and an older teen, the training includes instruction about human reproduction, development, and sexually transmitted diseases (STDs). It also contains a small group activity, in which the teens imagine the 10-year period after they hypothetically become sexually active at age 16. The teens are asked to assess the “baggage” they will have accumulated over this period and would be bringing into a permanent relationship. The training introduces the liber-
References


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Christine Cipperly is Respect Life Coordinator for the Catholic Diocese of Sacramento. She has worked as the HIV/AIDS Coordinator for Yolo County Department of Public Health from 1987 to 1999, a consultant and trainer for the California Department of Health Services, Office of AIDS, and Director of the Davis Free Clinic Drug Abuse Program in Davis, California.

Change in FOCUS Schedule

To sustain FOCUS over time—in an era of rising costs and decreasing HIV funding—we have decided to heed the advice of readers and reduce the number of times FOCUS comes out each year. As of January 2003, FOCUS will be published 10 times a year, with no issues in December or June. If you have any questions about this change, please contact Jennifer Jones at jejones@itsa.ucsf.edu or 415-502-4930.
Recent Reports

HIV Prevention for Young Heterosexuals

A review of recently published research concerning HIV sexual risk reduction strategies for heterosexual adolescents found that behavioral interventions have the largest effect on increasing condom use and acquisition and much smaller effects on encouraging abstinence and reducing the number of sexual partners.

The authors reviewed 36 controlled behavioral intervention studies that involved a total of 30,656 heterosexual adolescents, ages 11 to 21. All the studies involved an HIV sexual risk intervention and an assessment of HIV sexual risk-associated behavior. The mean age of the participants was 15.2 years, and 57 percent were female. The ethnic composition of the sample was: 41.6 percent African American, 34.2 percent White, 20.4 percent Latino, 5.8 percent Asian, and 1.0 percent Native American. The mean duration of contact was 7.0 hours (ranging from 20 minutes to 35 hours).

Two studies were particularly telling. The first study found that safer sex interventions were especially effective with sexually experienced sixth and seventh graders and had longer lasting effects than abstinence-based interventions on these teens. Participants were recruited from lower-income public schools in Philadelphia and included 659 African American students whose mean age was 11.8 years. Participants were divided into three groups for the eight-hour program: one received an abstinence-based intervention that mentioned condoms but stressed reducing frequency and delaying the initiation of sex, another stressed condom use, and the third, the control group, focused on general health promotion. Participants who received the abstinence-based intervention were less likely than the control group to have sex at the three-month follow-up but not at six or 12 months; those in the safer sex groups reported more frequent condom use than the control group at all follow-ups.

Another study with 246 low-income African American adolescents found that an intervention stressing behavioral skills—such as correct condom use, negotiating abstinence and condom use, and risk recognition—significantly reduced unprotected intercourse compared to a control intervention. The intervention consisted of an eight-session HIV cognitive-behavioral and skills training; the control group received a one session HIV education program. The participants, recruited from a comprehensive health center, had an average age of 15.3 years, and 72 percent were female. The study also revealed that participants who reported no sexual experience before the intervention were less likely than the control group to report—at the two-, six-, and 12-month follow-ups—having initiated sexual contact since the intervention.

Other topics of research included using teachers as facilitators of HIV risk reduction interventions and interventions with runaway youth. One article found that an HIV intervention with African American seventh and eighth graders was effective at reducing HIV risk behavior irrespective of the race or gender of the facilitators or the gender composition of the participant groups.

Abstinence and Comprehensive Sex Education

Although funding for abstinence has increased by 3,000 percent since 1996, an overwhelming majority of parents support a comprehensive sex education approach, according to a commentary on legislation and research on abstinence and comprehensive sex education programs in schools.

In a national poll of parents, 93 percent of respondents said they support a comprehensive sex education approach that includes information on abstinence, contraception, and condoms. Consistent with other research, 67 percent of the respondents rejected the notion that giving teens information about contraception in schools encourages them to have sex.

Despite these opinions, sex education has become more focused on abstinence since the late 1980s and is now significantly less likely to discuss birth control, abortion, and sexual orientation. In 1996, Congress passed a provision of the Social Security Act that gave $50 million to states, over five years, if their programs taught that “sexual activity outside marriage is likely to have harmful psychological and physical effects.” In 2000, Congress provided $60 million exclusively for abstinence-only programs.
Some studies have shown that students who participate in abstinence-only programs do not abstain from sex longer than those who do not participate in these programs, and often fail to use condoms or other forms of contraception. Programs that cover both abstinence and contraception not only promote safer sexual practices, but can also delay onset of intercourse and reduce the number of partners.

Risk Reduction among Adolescent Women


Condom use was the most frequently applied sexually transmitted disease (STD) prevention strategy for young heterosexual women, according to a study in a mid-Atlantic state. The strategy was not, however, universally or consistently used.

Researchers randomly selected 19-year-old women from the Department of Motor Vehicles register. They divided the 234 participants by ethnicity and contacted them to schedule a telephone interview. Interviews consisted of open-ended questions on risk reduction strategies. Researchers coded responses into seven mutually exclusive protective strategies. Of the participants, 39 percent were White, 33 percent were African American, and 28 percent were Hispanic. Because the Hispanic women were contacted after other subjects, their mean age was 21.4 years compared to 19.7 years for the White and African American women.

Although 47 percent of the women reported condom use, many respondents said they used condoms only with non-primary partners or early in relationships. Abstinence or postponing sexual contact was the second most common strategy, reported by 24 percent of the women; and 17 percent of the participants reported never having had sex with a man.

Among the other prevention strategies were: getting tested for HIV (16 percent), selecting “safe” partners (13 percent), negotiating condom use with partners (10 percent), talking about sexual risk histories with partners (7 percent), and monogamy or limiting the number of partners (7 percent).

Parents and Teen HIV Prevention

Bennett J, Contessa ST, Turner LC. Parent to parent: Preventing adolescent exposure to HIV. Holistic Nursing Practice. 1999; 14(1): 59–76. (New York City Department of Health.)

A pilot “train-the-trainers” program designed to prevent HIV transmission among teenagers at 10 public high schools in the Bronx found that a parent-to-parent HIV prevention curriculum was effective both at raising community awareness of teen HIV risk and at fostering conversations about risk between teens and their parents.

The Parent-to-Parent Pilot Program recruited parent trainer volunteers from parent organizations. Parents reflected the socioeconomic and ethnic diversity of the student population: 43 percent were Hispanic, 31 percent were Black, and 23 percent were White. Ages ranged from early thirties to sixties, and all had children between 13 and 18 years old.

Implemented by public health nurses, the program included a six-hour training with activities on: strategies for discussing attitudes about sex with teens, values concerning sex and possible inconsistencies among these values, how to talk about sexual topics (a role playing activity), and HIV epidemiology and risk factors. Each parent also agreed to give at least two 30- to 40-minute presentations to parent association meetings and other community groups; 60 percent of the parents achieved this goal.

Finally, the program sought to raise parent and community awareness about teen HIV risk not only through the parent presentations but also through the use of a “curious symbol.” The symbol, an image of pink gift box with a blue ribbon, which was worn as a button and displayed in the community, provoked conversation about the issue and the prevention program.

Next Month

Illness is a fertile environment for the destructive dynamics of loneliness: the stigma and fear related to HIV distances others from people with HIV, and the sense of failure and shame causes people with HIV to isolate themselves. In the February issue of FOCUS, Ami Rokach, PhD, Director of the Institute for the Research and Treatment of Psychosocial Stress in Toronto, examines the nature of loneliness and the ways in which people with HIV cope with it.

Social support can protect against loneliness, but social support programs have been criticized as frivolous in the politicized world of HIV funding. Also in the February issue, Ben-David Barr, MSW, a founder of the Seattle AIDS service organization, Gay City, reviews the research about the value of these programs.
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