Sex Education and Social-Emotional Development

A 2007 report by the Kaiser Family Foundation found that more teens reported learning about sex from friends and the media than from formal sex education or parental guidance.

While teen pregnancy rates have declined considerably over the past few decades in developed countries, the rate is still highest in the United States (57 per 1,000 15-19-year-olds), followed by New Zealand (51) and England and Wales (47).

Sedgh and colleagues, 2014

In 2013, CDC's Youth Risk Behavior Surveillance data indicated that 47% of high school students from grades 9 - 12 were engaging in sexual intercourse.

The following resource is based on six premises:

- *sexual behavior is a fundamental aspect of life;*
- *sexual development is a natural part of growing up;*
- *young people are receiving messages about and engaging in sexual activity;*
- *everyone has the right to equity of opportunity in learning how to lead a healthy life;*
- *it is society's responsibility to provide youth with the essential tools for developing the knowledge, skills, and attitudes associated with pursuing a healthy life;*
- *teaching to prepare individuals to pursue a healthy lifestyle begins early at home and at school.*

Our focus here is on the school's role related to sex education, with implications for social-emotional development. Because research doesn't support Abstinence-Only-Until-Marriage, we emphasize Comprehensive Sexuality Education programs.

What is Comprehensive Sexuality Education?

As implemented in schools, the degree of comprehensiveness of a sexuality education curriculum varies. A synthesis of what has been proposed suggests the following:

> Sexuality education draws from what science can offer related to sexual knowledge, attitudes, and behavior. The teaching emphasizes that sexuality is a natural part of healthy living. It encompasses biologically and medically accurate information about sexual activity as well as sexuality. It relates the diverse values and beliefs represented in a community, society, and culture. In a psychological and societal context, it promotes healthy social and emotional development. Properly taught, it enhances feelings of self-determination, competence, and connection with significant others and expands knowing oneself.
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> Schools can complement and augment what children learn from their families, religious and community groups, peers, health care professionals, and from the media. A comprehensive approach starts in kindergarten, continues through high school, and entails lifelong learning. It covers a wide range of topics in ways that are a good match with a student's development, motivation, and cultural background.

Schools can complement and augment what children and adolescents learn elsewhere

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Examples of topics include sexual and reproductive knowledge, puberty and development, responsible sexual expression and decision making, sexual orientation, body image, relationships, masturbation, gender identity, sexual violence, abstinence, contraception and condoms to prevent unwanted pregnancies and sexually transmitted diseases, and more. Embedded in all this is the need and opportunity to facilitate social and emotional learning (e.g., appreciation of and respect for self and others, enhanced personal and interpersonal competence).

Comprehensive Sex Education Vs. Abstinence-Only Programs

Opponents of comprehensive sexuality education say it encourages premarital sexual activity among teens. They state that sexual activity outside of marriage is harmful socially, psychologically, and biologically. From a physical health perspective, advocates for abstinence-only programs argue that abstinence is the best way to avoid HIV and other sexually transmitted diseases and reduce the rate of teen pregnancy. For religious reasons, a subgroup morally opposes the endorsement of contraception and premarital sex. Those advocating for abstinence-only programs don't accept the research findings indicating that such programs are not effective in reducing teenage pregnancy rates and delaying teens initiating sexual intercourse. And they tend to set aside data indicating that comprehensive sexuality education programs do delay initiation of sex, increase condom and contraception use, and help develop healthier sexual attitudes and behaviors.

Federal and State Role in Sex Education

Because school control is constitutionally a state and local matter, the federal government does not have any direct authority over school programs. Federal legislation, however, offers funding (and related mandates) for various school programs. With respect to sex education, some federal funding has been available to schools and community-based agencies for various forms of sex education. However, continuous controversy has plagued the efforts. In 2016, federal legislation was introduced (i.e., the Real Education for Health Youth Act of 2016) aimed at redirecting federal policy. If such a bill were enacted, it would require the Department of Health and Human Services to "award competitive grants for: (1) comprehensive sex education for adolescents, (2) comprehensive sex education provided by institutions of higher education, and (3) training faculty and staff to teach comprehensive sex education to elementary and secondary school students." The language of the bill specifies that "grants cannot be used for health education programs that:

Continuing controversy plagues federal sex ed policy

- deliberately withhold health-promoting or lifesaving information about sexuality-related topics, including HIV;
- are medically inaccurate or have been scientifically shown to be ineffective;
- promote gender stereotypes;
- are insensitive and unresponsive to the needs of survivors of sexual abuse or assault, sexually active youth, or lesbian, gay, bisexual, transgender, queer, and questioning youth; or
- are inconsistent with the ethical imperatives of medicine and public health."

Also note that the bill calls for amending (a) "the Public Health Service Act to remove limitations on using AIDS prevention program funding for education or information that promotes certain sexual activity or intravenous substance abuse," (b) "the Elementary and Secondary Education Act of 1965 to allow funding to be used for contraceptive distribution in schools," and "title V (Maternal and Child Health Services) of the Social Security Act to repeal the program for abstinence education."

At the state level, the National Conference of State Legislatures reports that, as of March 1, 2016, all states are involved to some degree with sex education for public school children. As reported:

All states are involved in sex ed policy

- 24 states and the District of Columbia require public schools teach sex education (21 of which mandate sex education and HIV education).
- 33 states and the District of Columbia require students receive instruction about HIV/AIDS.
- 20 states require that if provided, sex and/or HIV education must be medically, factually or technically accurate. State definitions of "medically accurate" vary, from requiring that the department of health review curriculum for accuracy, to mandating that curriculum be based on information from "published authorities upon which medical professionals rely." (See table on medically accuracy laws at http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx#2 .)

Many states define parents' rights concerning sexual education:

- 38 states and the District of Columbia require school districts to allow parental involvement in sexual education programs.
- Four states require parental consent before a child can receive instruction.
- 35 states and the District of Columbia allow parents to opt-out on behalf of their children.

http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx

Teaching About Sexuality

The aim, of course, is to teach about (a) sexual health, (b) engender responsible sexual behavior and relationships, and (c) promote personal well-being. Such teaching includes a focus on cognitive development (knowledge), emotional development (feelings, values, attitudes), and behavioral development (effective communication, positive relationships, appropriate decision-making, personal and interpersonal problem-solving, etc.).

Concern for matching learner readiness

As with any content, effective personalized teaching and learning requires matching a learner's motivation and levels of cognitive, social, and emotional development. Those who have developed standards, curriculum, and lessons plans for comprehensive sexuality education tend to provide guidelines mainly in terms of age-appropriate content. Effective instruction requires refining such guides to better match a learner's current motivation, capabilities, and states of being.

Resources

The following are online sources to aid schools and communities in teaching sexuality:

- *The Future of Sexuality Education (FoSe)* – offers the National Sexuality Education Standards for quality school-based sexuality education. http://www.futureofsexed.org/documents/josh-fose-standards-web.pdf
- *Sexuality Information and Education Council of the United States* (SIECUS) – For over a decade, SIECUS has published *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade* to help educators create new sexuality education programs and evaluate already existing curricula - http://www.siecus.org/_data/global/images/guidelines.pdf. SIECUS also has a SexEd Library that provides a comprehensive online collection of lesson plans for sexuality education - http://www.sexedlibrary.org/index.cfm
- *Centers for Disease Control and Prevention (CDC)* - CDC offers a *Health Education Curriculum Analysis Tool* designed to help school districts, schools, and others analyze health education curricula based on the National Health Education Standards and the Centers for Disease Control and Prevention's Characteristics of an Effective Health Education Curriculum - http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf

What About Subgroups?

Various subgroups are mentioned frequently as at elevated risk for physical and mental health problems related to sexual behavior. Concerns about equity also have highlighted the need to ensure all students have an equal opportunity to receive comprehensive sexuality education. All this underscores the need for paying particular attention to the needs of and ensuring greater representation of marginalized and stigmatized subgroups (e.g., youth of color, LGBTQ+ youth, those in special education, homeless youth, those in foster care, immigrants, sexually abused youth).

LGBTQ+: One Subgroup's Concerns about Current Sex Education

Pingel, et al (2014) found that young homosexual males reported receiving "inadequate sexual health information" and felt that their needs were not properly addressed within the existing curriculum. The reports revealed that the existing curriculum was limited to heterosexual sex and stressed abstinence- only sex education. They voiced concerns about how limited the abstinence-only programs were and how these programs emphasized the negative consequences of participating in sexual activity before marriage. Many participants voiced frustration that the "how-to" component only discussed penile- vaginal intercourse. Due to program limitations, many participants reported how unprepared they felt to engage in safe sex, and that they lacked the skills to communicate their sexual needs and desires to their partners. Additionally, they stated that the silence related to discussing homosexuality perpetuated the negative stigma associated with non-heterosexual orientations.

Participants discussed how due to the limitations of the sex education curriculum within their own schools, they were forced to turn to the internet for help (not always accurate).

Pingel notes that educators are only required to discuss sexual orientation in twelve states and "three of those states required educators to emphasize negative associations with non-heterosexual orientations."

The Centers for Disease Control and Prevention reports finding that students of homosexual orientation "were less likely to report engaging in safe sex practices such as using condoms during their last sexual encounter."

Examples of Effective Comprehensive Sex Education Programs

In 2008, Advocates for Youth compiled information on twenty-six programs that had been positively evaluated. Program effectiveness was based on four criteria: risk avoidance through abstinence, risk reduction for sexually active youth, reduced rates of teenage pregnancy or sexually transmitted infections, and increase receipt of health care or increases compliance with treatment protocols. The two examples highlighted below are representative of this set of programs.

Safer Choices

Safer Choices is "a 2-year, multi-component STD, HIV, and teen pregnancy prevention program for high school students. The program aims to reduce the frequency of unprotected sex by reducing the number of sexually active students and increasing condom use and other methods of pregnancy protection among students who are sexually active. It seeks to motivate behavioral change by addressing factors such as attitudes and beliefs (including self-efficacy), social skills (particularly refusal and negotiation skills), functional knowledge, social and media influences, peer norms and parent/child communication" (http://www.etr.org/ebi/programs/safer-choices/).

Evaluation findings were gathered from the implementation of *Safer Choices* in 20 schools in California and Texas (Kirby, Baumler, Coyle *et al*. 2004). Throughout 20 sequential sessions over the course of two years, Safer Choices provided HIV/STI knowledge to students, modified attitudes and norms about condom use and barriers to condom use, encouraged students to use their right to refuse sex, avoid unprotected sex, use condoms, and communicate with partners about safer sex, changed perceptions of risk for infection with STIs, and improved communication with parents. Along with sex education curriculum, the intervention included a school health protection council, a peer team to sponsor school-wide activities, parenting education, communication and cooperation between schools and the community, and an HIV-positive speaker in selected schools. The program had "reduced one or more measures of sexual risk taking over 31 months among all groups of youth and was especially effective with males, Hispanics, and youth who engaged in unprotected sex." "Its greatest overall effect was an increase in condom use among students who had engaged in unprotected sex before the intervention."

Reach for Health Community Youth Service

Reach for Health Community Youth Service targets African-American and Hispanic youth living in urban areas. The program combines a classroom teaching component with community service work. The health curriculum focused on decreasing drug and alcohol use, violence, and sexual behaviors that may result in teen pregnancy or transmissions of STIs. The intervention also is intended to provide opportunities for middle school students to participate in 3 hours of service activities within their communities.

"The intervention was initially delivered in 1994 to two large middle schools in Brooklyn, NY; one school was designated as the intervention school, the other as the control. A total of 68 classrooms participated in the initial implementation. In the control school, 33 classrooms (584 students) received the standard New York City health education program, which included some mandated lessons on drugs and AIDS. Within the intervention school, 22 classrooms (222 students) were randomly assigned to receive core *RFH* curriculum (classroom component only). The remaining 13

intervention classrooms (255 students) received the enhanced *RFH* plus Community Youth Services program (*RFH-CYS*). Bi-lingual and special education classes were included from both school sites. At follow-up six months later, reports of sexual activity were higher across the sample. However, students in the control condition showed greater increases in risk behavior (ever had sex, recent sex, recent sex without condom, recent sex without birth control) than did their peers in the treatment conditions. In contrast, students in both intervention conditions showed increases in their use of STD protection and birth control. Also noteworthy are the findings that eighth graders and special education students showed the greatest improvement." http://www.socio.com/paspp10.php

Note that some educators have advocated for integrating sex education into the biology curriculum in middle and high school. Also proposed is that a "parallel social studies curriculum" be implemented to "address risk-aversion behaviors and planning for the future" (Stanger-Hall & Hall, 2011).

Efforts to provide peer sex education programs also should be noted. An example is the Teen Prevention Education Program implemented in North Carolina high schools. Peers conduct workshops for younger high school students aimed at increasing students "knowledge, skills, and behaviors associated with avoiding an unintended pregnancy, HIV, STIs, and other health issues." The program also seeks to create a "school climate that supports healthy decision making" (Layzer, Rosapep, & Barr, 2014). The workshops encourage positive peer pressure, provide knowledge about sexual health issues, and offer opportunities for youth to practice ways to communicate to decrease the chance of engaging in risky sexual behaviors. The workshops typically begin with a large-group presentation and then continue with small-group activities that provide informed discussions about sexual behaviors and risks. Reports from participants suggest that they find the program helpful with both social well-being and sexual health and that they felt learning from peers was more effective and personalized compared to receiving instruction from a traditional health class. Initial findings also suggest the program provided greater familiarity with community resources, improved school climate by increasing connectedness to school, and helped participants develop social and behavioral skills to avoid risky behaviors.

Concluding Comments

Clearly, sexuality education involves more than understanding the anatomy and the physiology of biological sex and reproduction. It is central facet of social-emotional development and integral to whole child development.

As Breuner and Mattson (2016) note, sexuality education

> *covers healthy sexual development, gender identity, interpersonal relationships, affection, sexual development, intimacy, and body image for all adolescents, including adolescents with disabilities, chronic health conditions, and other special needs. Developing a healthy sexuality is a key developmental milestone for all children and adolescents that depends on acquiring information and forming attitudes, beliefs, and values about consent, sexual orientation, gender identity, relationships, and intimacy.*
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> *Healthy sexuality is influenced by ethnic, racial, cultural, personal, religious, and moral concerns. Healthy sexuality includes the capacity to promote and preserve significant interpersonal relationships; value one's body and personal health; interact with both sexes in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values, sexual preferences, and abilities.*

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A Few Additional Online Sexuality Education Resources for School and Community

- *United Nations Population Fund* – http://www.unfpa.org/public/home/adolescents/pid/6483 Among its advocacy agenda, it supports promotion of comprehensive sexuality education and provides programming guidance for both school and community settings.
- *The National Alliance to Advance Adolescent Health* – http://www.thenationalalliance.org/ Focuses on ways to improve and increase access to integrated physical, behavioral, and sexual health care for adolescents.
- *Advocates for Youth* – https://www.advocatesforyouth.org/ Provides advocacy, information, and many sex education resources for professionals and families.

For a working list of other organizations that support Comprehensive Sexuality Education – http://www.communityactionkit.org/index.cfm?pageId=926