ACP position paper

Abstinence education*

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The American College of Pediatricians strongly endorses abstinence-until-marriage sex education and recommends adoption by all school systems in lieu of “comprehensive sex education.” This position is based on “the public health principle of primary prevention—risk avoidance in lieu of risk reduction,” upholding the “human right to the highest attainable standard of health” (Freedman 1995).

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By every measure, adolescent sexual activity is detrimental to the well-being of all involved, especially young women, and society at large. Children and adolescents from 10 to 19 years of age are more at risk for contracting a sexually transmitted infection (STI) than adults (Centers for Disease Control and Prevention (CDC) 2007). This is due to the general practice of having multiple and higher risk sexual partners, and to the immaturity of the cervical tissue of girls and young women. The CDC recently stated that of the 19 million new cases of STIs annually reported in the United States, 50 percent occur in teens and young adults under 25 years of age (CDC 2007). Twenty-five percent of newly diagnosed cases of HIV occur in those under 22 years of age (Sulak and Herbelin 2005, 30). This translates into

one in four sexually active female adolescents being infected with at least one STI (Department of Health and Human Services (HHS) 2008).

Bacterial STIs may cause life-threatening cases of pelvic inflammatory disease and infertility. Viral STIs which include herpes, the human papilloma virus (HPV), and HIV are generally incurable. Herpes afflicts its victims with life-long painful recurrences, may be passed on to sexual partners even when asymptomatic, and may be life threatening to infants if passed on at birth during vaginal delivery. HPV is found among 90 percent of sexually active young adults and teens (Sulak and Herbelin 2005, 31). While often self-limited, HPV has high-risk strains that may persist for life and cause cancer of the cervix. HIV not only causes premature demise, but also significant suffering with life-long dependence on multiple toxic and costly medications. The CDC

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estimates that STIs cost the U.S. Health Care System as much as \$15.3 billion dollars annually (CDC 2009).

Adolescent pregnancy is similarly associated with adverse socioeconomics that have an impact on the family, community, and society at large. One in thirteen high school girls becomes pregnant each year (Sulak and Herbelin 2005, 31). Adolescent pregnancy results in decreased educational and vocational opportunities for the mothers, an increased likelihood of the family living in poverty, and significant risk for negative long-term outcomes for the children. For example, children of adolescent mothers are more likely to be born prematurely and at a low birth weight; suffer from poor health; perform poorly in school; run away from home; be abused or neglected; and grow up without a father (Guttmacher Institute 2006).

Even if sexually active teens escape acquiring STIs and becoming pregnant, few remain emotionally unscathed. Overall, one in eight teens suffers from depression (Meeker 2007, 68), and suicide has risen to become the third leading cause of death for adolescents, paralleling the rise in STIs within this population (Meeker 2007, 68). Infection with an STI has long been recognized as a cause for depression among teens. More recently, however, adolescent sexual activity alone has been acknowledged as an independent risk factor for developing low self-esteem, major depression, and attempting suicide (Hallfors et al. 2004). In studies that controlled for confounding factors, sexually active girls were found to be three times as likely to report being depressed and three times as likely to have attempted suicide when compared with sexually abstinent girls (McIlhaney and Bush 2008, 78). Sexually active boys were more than twice as likely to suffer from depression and seven times as likely to have attempted suicide when compared with sexually

abstinent boys (McIlhaney and Bush 2008, 78). This is not mere coincidence. Scientists now know that sexual activity releases chemicals in the brain that create emotional bonds between partners. Breaking these bonds can cause depression, and make it harder to bond with someone else in the future (McIlhaney and Bush 2008, 77–78).

Sexual activity is defined as genital contact. This includes mutual masturbation, as well as oral, vaginal, and anal intercourse. While only vaginal intercourse may result in pregnancy, all of these practices may spread STIs, and lead to emotional trauma. Abstaining from all sexual activity is the only 100 percent safe and effective way to avoid teen pregnancies, STIs, and the emotional fallout of adolescent sexual activity. Almost 40 years of emphasis on “safer sex” with “values-neutral sex education,” condoms and contraception has clearly failed our young people. Abstinence education does not occur in a vacuum, making it especially difficult to separate its influence from the opposing influence of the media and cultural milieu. Nevertheless, effectiveness of abstinence sex education in delaying the onset of sexual debut has been demonstrated in rigorous scientific studies. For example, five out of seven programs recently reviewed showed a significant reduction in sexual initiation rates (two programs showed rates decreased by half) (Weed 2008). Evaluation of community-based abstinence programs in peer-reviewed journals showed that they are effective in significantly reducing pregnancy. According to an April 2008 report by the Heritage Foundation “fifteen studies examined abstinence programs and eleven reported positive findings of delayed sexual initiation” (Kim and Rector 2008). Reviews by the Institute for Research and Evaluation state that “several well designed evaluations of abstinence programs have found significant long-term reductions in adolescent sexual activity” (Institute for Research and Evaluation

2007). These do not begin to thoroughly evaluate the hundreds of ongoing programs.

In its endorsement of abstinence-based sex education, the *College* calls attention to the scientific controversies surrounding alternative educational platforms. Most sex education curricula fall into two categories, *abstinence-until-marriage* or *comprehensive sex education programs* (occasionally also referred to as “abstinence plus” programs). Recently, abstinence education has been criticized for not providing critical health information about condom use. Abstinence education curricula, however, do not discourage the use of condoms; rather they note that chastity obviates the need for condoms. Abstinence education programs do not claim that condoms have no place in preventing STIs. Comprehensive programs, on the other hand, are misleading in the emphasis they place on condom use. These programs give teens the impression that condoms make sexual activity safe. In reality, there has been much conflicting medical literature on the effectiveness of condoms in preventing STIs since the 2000 NIH (National Institutes of Health) report on the subject and much of the controversy remains unresolved (National Institute of Allergy and Infectious Diseases, NIH, HHS 2000). Teens must be informed that condoms do not offer complete protection from either pregnancy or STIs.

The *College* position supporting abstinence-until-marriage education, unlike alternative education platforms, also recognizes the unique neurobiology of adolescent brains. The frontal cortex of the adolescent brain is still in development and unable to make the consistently wise executive decisions necessary to control action based on emotional input. Researcher Jay Giedd and others have found that young people do not have the physical brain capacity to make fully mature decisions until their mid-twenties (Strauch 2003, 16).

Consequently, when it comes to sex education, adolescents need to be given clear direction repeatedly, as is done with programs that address smoking, drugs, and alcohol use. Emphasis on contraceptive methods undermines the authority of parents and the strength of the abstinence message. This approach reinforces the ubiquitous (yet erroneous) message presented by the media that engaging in sexual activity is not only expected of teens, but also the norm. Adolescent brains are not equipped to handle these mixed messages. Parents and teachers need to “function as a surrogate set of frontal lobes, an auxiliary problem solver” for their teens, setting firm and immutable expectations (Medical Institute for Sexual Health 2005). Adolescents need repetitive, clear, and consistent guidance.

As families address this issue of sex education, the American College of Pediatricians recommends that parents be fully aware of the content of the curriculum to which their children are being exposed. The national “Guidelines for Comprehensive Sex Education” that were drafted by the Sexuality Information and Education Council of the United States (SIECUS) place strong emphasis on “values neutral” sex education beginning in *kindergarten*. According to these guidelines, children between the ages of 5 to 8 years should be taught not only the anatomically correct names of all body parts, but also the definitions of sexual intercourse, and masturbation (SIECUS 2004).

Overall, these comprehensive programs only emphasize “safer sex.” Many comprehensive programs also provide sexually erotic material to teens with explicit condom demonstrations. Other programs suggest alternative types of sexually stimulating contact (referred to as “outercourse”) that would not result in pregnancy but still could result in STIs. Some of these activities, depending on the ages of those

involved and the state in which they occur, could actually be illegal. These education programs can break down the natural barriers of those not yet involved in sexual activity and encourage experimentation. Additionally, many programs emphasize that teens do not need parental consent to obtain birth control and that teens therefore need not even discuss the issue with them (HHS 2007, 6–7).

Discouraging parental involvement eliminates one of the most powerful deterrents to sexual activity, namely, communication of parental expectations (McNeely et al. 2002; Sieving et al. 2000). Firm statements from parents that sex should be reserved for marriage have been found to be very effective in delaying sexual debut. Parental example and “religiosity” have also been found to be similarly protective. Adolescents reared by parents who live according to their professed faith (Manlove et al. 2006) and are actively involved in their worship community (Sinha, Cnaan, and Gelles 2007), are more likely to abstain from sexual activity as teens. Successful sex education programs involve parents and promote open discussion between parents and their children.

The American College of Pediatricians also believes parents should be aware of the current state of funding, and government involvement in sex education choices. Comprehensive programs receive seven to twelve times the funding of abstinence programs (Pardue, Rector, and Martin 2004, 8). However, according to a recent study by the HHS, comprehensive programs do not give equal time to abstinence (HHS 2007, 6).

In 2004 Congressman Henry Waxman of California presented a report before Congress critical of the medical accuracy of abstinence education curricula (Waxman 2004). The Mathematica Study was similarly critical of the medical accuracy of abstinence education programs

(Institute for Research and Evaluation 2007). However, in 2007 the HHS conducted an extensive review of nine comprehensive sex education curricula using the same methods employed by Congressman Waxman and the Mathematica Study. These comprehensive programs were found to have no better record for medical accuracy. The HHS review also found that the comprehensive programs were hardly comprehensive. The amount of discussion dedicated to “safer sex” exceeded that spent on abstinence by a factor of up to seven. Some of the programs failed to mention abstinence altogether. None of the programs carefully distinguished between reducing and eliminating the risks of sexual activity, and nearly every program failed to mention the emotional consequences of early sexual activity. Although some of the comprehensive programs showed a small effect in reducing “unprotected” sex (seven of nine programs) and to a lesser extent in delaying sexual debut (two of eight programs), the impact did not extend beyond six months (HHS 2007, 8).

According to a 2004 Zogby Poll, 90 percent of adults and teens agree with the American College of Pediatricians position that teens should be given a strong abstinence message (With One Voice 2004). Programs that teach sexual abstinence until marriage are about much more than simply delaying sexual activity. They assist adolescents in establishing positive character traits, formulating long-term goals, and developing emotionally healthy relationships. These programs increase the likelihood of strong marriages and families—the single most essential resource for the strength and survival of our nation.

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other healthcare professionals dedicated to the health and well-being of children. Formed in 2002, the College is committed to fulfilling its mission by producing sound policy, based upon the best available research, to assist parents and to influence society in the endeavor of child-rearing. Membership is open to qualifying healthcare professionals who share the College's Mission, Vision and Values. The home office is in Gainesville, Florida, the website is <http://www.acped.s.org> and the office telephone number is 888-376-1877.

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BIOGRAPHICAL NOTE

For over 35 years Aleen Zeiler, MD has practiced pediatrics at St. Vincent Mercy Medical Center in Toledo, Ohio. She graduated from the Medical College of Ohio (now University of Toledo Medical College) in 1974. She is on the clinical faculty there and at Ohio University teaching medical students and residents in a busy urban practice. For many years she was Medical Director of Positive Choices, an abstinence until marriage (now called sexual risk avoidance) program which served many schools and community programs in the area. She provides medical services at a local high school in a program called Access to Health. She also enjoys being involved in medical mission projects in the Dominican Republic. She has been married for 35 years and has 3 adult children and 2 granddaughters.