THE EFFECTS OF ABSTINENCE-ONLY SEXUAL EDUCATION ON YOUNG ADOLESCENTS

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by

Sydney Jean Berenzweig

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DEDICATION

I dedicate this thesis to my family. Specifically, my grandparents (Dr. Harold and Ellen Berenzweig, and Jacque and Gary Steinberger), siblings (Mark, Danelle, Tara, Jason, Catherine, Kenneth, and Jacob) parents (Steven and Wendy), aunts (Shana and Shelly), uncle (Michael), nieces (Taryn, Teyla, and Tiah), nephews (Mark and Alester), and pets. Thank you for supporting me throughout the years and giving me the structure to complete this paper. Along with the people mentioned above I would like to thank my best friend Madison. Thank you for being with me and supporting me throughout my hardest and weirdest years of my life.

I would also like to dedicate the paper to the following teachers/professors. Cherilin Saladrigas, thank you helping me throughout my high school experience and helping me find my passion in life. Dr. Andrey Koptelov, thank you for helping me grow as a young professional. Dr. Jill Pagels for showing me compassion through my college experience and showing me how to be a great educator both academically and in a personal manner. Lastly, thank you Dr. William Edgington for showing me how to make content interesting in class, giving me tools to use throughout my career, and helping me with this thesis.

ABSTRACT

Student, Sydney B., *The Effects of Abstinence-Only Sexual Education on Young Adolescents*. Bachelor of Science in Education, November, 2020, Sam Houston State University, Huntsville, Texas.

Abstinence-only sexual education has been taught throughout schools privately throughout the years but then gained traction and support in the 1960s [7]. It wasn't until the 1980's though that Americans started to oppose it and start actively fighting against the practice [7]. Many studies have been done through both sides of the debate to try and prove their point with only one side wielding unbiased and correct data to prove their point. This essay is in effect of the Pro-Comprehensive side of the debate and will explain many definitions, studies, and data from both sides of the debate but with a primary focus on the Pro-Comprehensive side of the debate.

The methodology to find the information supporting the topic supported was found through a survey done using Google Form (turned out not to work with my thesis), searching for peer-reviewed articles on Google Scholar, and a Google search looking for reliable websites with pertinent information.

ACKNOWLEDGEMENTS

I would like to acknowledge Dr. William Edington for helping me throughout the thesis process and being the director of this paper, the Education department of Sam Houston State University for approving my topic, Dr. Andrey Koptelov for finding me a conference to present at, Dr. Jill Pagels for helping me edit my thesis, and Dr. Kimberly Bell for giving me the opportunity to present a topic in which I am passionate.

PREFACE

I choose this thesis topic for a few reasons. The first reason being that with a comprehensive sexual education and access to birth control (seen many times as a pair) the abortion rates in that area go down. This would significantly help the abortion debate in America. The second reason is we as a country are violating human rights by no giving comprehensive sex education to our youth. The third reason is that most people do not know how to protect themselves when they inevitably have sex with can have some long-lasting repercussions on their life as well as the people around. The last reason why I choose this topic is because I was in a abstinence only sexual education program and for me, as well as many of my peers, it did more harm than good and I want to try and stop that cycle as much as possible.

I choose Dr. Edgington as my director because of the experiences I've had with him in the courses I've taken under him. He is straight to the point, but in an encouraging way, is always there to help, and is extremely knowledgeable on the age group I'll be discussing.

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CHAPTER I

Background

Definition, Names, and Examples

Before going into what an abstinence education, you first must go into what the definition of abstinence is. The definition can change from person to person as there is no clearly defined definition. Most will describe it as delaying sex, restraining from any sexual acts, to not having heterosexual vaginal sex/homosexual anal sex. Depending on the person defining abstinence it could or could not include oral sex, anal sex, masturbation, stimulation using hands, kissing, and touching [1,17,38]. Because of how varied the definition can be from person to person two people who claim to be virgins could have different sexual pasts. An example of this is Girl A could have never had a kiss or been touched in a sexual way by a member of the preferred sex, Girl B could have participated in kissing and oral sex, and Girl C could have participated in anal sex while depending on who is defining abstinence they could all three be considered virgins.

Abstinence-only sexual education has been used all over the United States and currently goes by a few names. The first name is Abstinence Education with three sub variations, AOE (standing for abstinence only), and Abstinence-until-marriage programs. The three subsections of the Abstinence Education can be seen in Table 1 [4,23,31,38,40].

Table 1: Types of Abstinence Education Programs
Abstinence-Only Education – Also called "Sexual Risk Avoidance." Teaches that abstinence is the expected standard of behavior for teens. Usually excludes any information about the effectiveness of contraception or condoms to prevent unintended pregnancy and STIs. Sometimes must adhere to the 8-point federal definition.
Abstinence-"Plus" Education – Stresses abstinence, but also includes information on contraception and condoms.
Comprehensive Sex Education – Provides medically accurate age-appropriate information about abstinence, as well as safer sex practices including contraception and condoms as effective ways to reduce unintended pregnancy and STIs. Comprehensive programs also usually include information about healthy relationships, communication skills, and human development, among other topics.

Depending on the program, they may or may not teach the students what steps to take in the case of a rape. This could lead to rape cases going unreported, evidence being tampered, multiple rape offenses, and victim blaming.

The United States has an eight-point definition of Abstinence, known as the A-H Definition, any state program that receives federal funding must adhere to the systems regulation. There is still some wiggle room when it comes to how the schools provide the information to their students.

Table 2: 8-point "A-H" Federal Statutory Definition of Abstinence Education (applies to Title V AOUM Programs)
A. has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity
B. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children
C. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems
D. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity
E. teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects
F. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society
G. teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances
H. teaches the importance of attaining self-sufficiency before engaging in sexual activity
SOURCE: Section 510 (b) of Title V of the Social Security Act, P.L. 104–193

Although the eight-point system is the federal definition in the journal, "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S" they categorize their data by splitting into four levels. The higher the number, the higher the emphasis on abstinence rather than a more comprehensive program. Level 0 is a completely comprehensive program, focusing on safe sex practices, HIV/STIs, and the next steps if conception occurs. Level 0 does not specifically mention abstinence. Level 1 is partly a comprehensive program. It teaches abstinence along a regulated HIV/STI/safe sex curriculum. Level 2 has a strong focus on

abstinence but will still teach the HIV/STI curriculum excluding contraception. Level 3 focuses only on abstinence until marriage and will not teach about any part of the HIV/STI curriculum [40].

Since this form of sexual education has been around for decades, there are many stories from those who went through the programs. A common theme throughout the programs is referring to females as pieces of tape, gum, or an apple, all being a visual way to get the message across (there are many more that weren't as common as the ones mentioned). The "tape method" is when the instructor will take a piece of tape and continually stick it to either themselves, others, or themselves until the tape loses most if not all its stickiness. The "gum method" has two variations. The first variation is where the instructor chews the gum and shows how destroyed it is, the second variation is where the instructor chews a piece of gum and offers the chewed piece of gum to the group/class. With an apple the instructor will give an apple a student and tell them to take a bite, then will try to get other students to take a bite from the same apple in the same spot or touching the original spot. All of these methods are to show the young girls that "no man will want you once you have been used (i.e. lost your stickiness, been chewed, or already bitten into depending on the methods). Usually the above methods are used in conjunction with other scare tactics. A few of these include showing severe cases of STI's, the "dice game" where if the dice lands at the number you are at you either get pregnant or an STI, and depending on the school they will bring religion into the conversation to further the impact given to the students.

Due to the Abstinence- Only Programs many young adolescents have made their title of virgin as part of their personality. An example of this the movement created by the

National Longitudinal Survey of Youth, the virginity pledge movement. The over 2.5 million members that pledge to this group agree to stay abstinent until marriage, but many studies show that many of the members break their pledge. The members of this group are ages 12-18 and although some stay abstinent until marriage, most members delay initiation of intercourse by an average of 18 months [5,38]. When they decide to participate in intercourse the often fail to practice safe sex as they are not educated in the subject. This leads to increase in the prevalence of STI's throughout group members. These members tend to marry earlier than their non-member peers and 88% of members participate in premarital-sex before marriage while 99% of their non-member counterparts participated in premarital-sex [38].

Why is it supported

Often when Americans are asked why they support the Abstinence only programs if the response is not for religious reasons its because of "the values" it teaches the young ladies. Many believe that teaching children (specifically girls) to wait until marriage to have sex will teach them to be responsible, how to keep a long faithful monogamous marriage, and self-preservation [22,31,38].

Although the United States does not have a declared national religion, the majority of the population is a Christian denomination or apart of a religion who believe in one or more Gods. Due to this they believe that if a woman is pregnant it was God's plan for them and if anything happens to the fetus (abortion or in some case miscarriages) that it is considered murder. As a result of this they believe that if women do not have sex until they are wed then abortion rates will go down along with teen pregnancy rates. Even though

there is supposed to be separation of church and state, religion continues to affect policy making, political platforms, and education in public schools.

Acts and Funding

There are have been multiple acts, policies, and programs in support of Abstinence Education programs. Some major policies on Abstinence Only Programs include the Adolescent Family Life Act (AFLA), the Community-Based Abstinence Education program (CBAE), Section 510 of the 1996 Social Security Act, and Title V Abstinence-Only-Until-Marriage Program (AOUM) [19,31,38]. The Social Security act is funded by grants from Special Projects of Regional and National Significance (SPRANS). The SPRANS program funds many community-based religious organizations and can bypass the state-approval set up by Section 510. Programs are prohibited from educating about contraceptives (both how to use and to gain access to them), and anything to do with the LGBT community including orientation, gender, and safe sex practices regarding homosexual relationships if funded by the above acts [38]. These acts all adhere to the 8-point definition/rules mentioned previously and must teach the information to adolescents ages 12-18 years old. [31,38]. Any programs retrieving funding from any of these acts cannot teach anything outside of the 8-point definition, specifically safe-sex practices even with their own funding as it is prohibited [38]. Along with this, any program getting funding from Title V must match every 4 dollars given with 3 dollars of their own [4,31,38]. Some examples of the more well-known programs can be seen in Table 3 (below).

Table 3: Current Federal Funding Streams for Sex Education
Title V Abstinence-Only-Until-Marriage (AOUM), *established 1996* – Created under the Welfare Reform Act and reauthorized as the State Abstinence Education Grant Program in 2010. All programs must adhere to the federal A-H definition, and states must match every four federal dollars with three state dollars. Information about contraceptives and condoms may not be provided unless to emphasize failure rates.
Personal Responsibility Education Program (PREP), *established 2010* – Enacted under the ACA, PREP awards grants to state health departments, community groups, and tribal organizations to implement medically accurate, evidence-based, and age-appropriate sex education programs that teach abstinence, contraception, condom use, and adulthood preparation skills. States receive grants based on the number of young people (ages 10-19) in each state, and programs must target those at high risk. 44 states and DC received PREP funding in FY2017.[1]
Teen Pregnancy Prevention Program (TPPP), *2010 – 2018* – A five-year competitive grant program established in 2010 under the ACA that funds private and public entities who work to reduce and prevent teenage pregnancy through medically accurate and age-appropriate programs, especially in communities at high risk. TPPP supports program implementation and capacity building for grantees, as well as development and evaluation of new approaches to teen pregnancy prevention. There are currently 84 TPPP grantees. However, the Trump Administration has released a new funding announcement that focuses on programs that teach abstinence instead of comprehensive sex education.
Sexual-Risk Avoidance Education (SRAE), *established 2012* – Formerly known as the Competitive Abstinence Education Program (CAE), the program "seeks to educate youth on how to voluntarily refrain from non-marital sexual activity and prevent other youth risk behaviors." All information provided must be medically accurate and evidence-based.
Division of Adolescent and School Health (DASH), *established 1988* – DASH provides funding to state education agencies and local school districts to increase access to sex education, as well as to reduce disparities through the provision of HIV and STI prevention to young men who have sex with men. DASH also supports surveillance on youth risk behaviors and school health policies and practice.

The United States government has put a significant amount of funding in favor of Abstinence-Only Programs. This included raising the funds for these programs to $90

million for the 2017 fiscal year, $5 million more than the previous year [4]. Figure 1 shows how Federal Funding was distributed in the fiscal year 2017 for all sexual education programs [31].

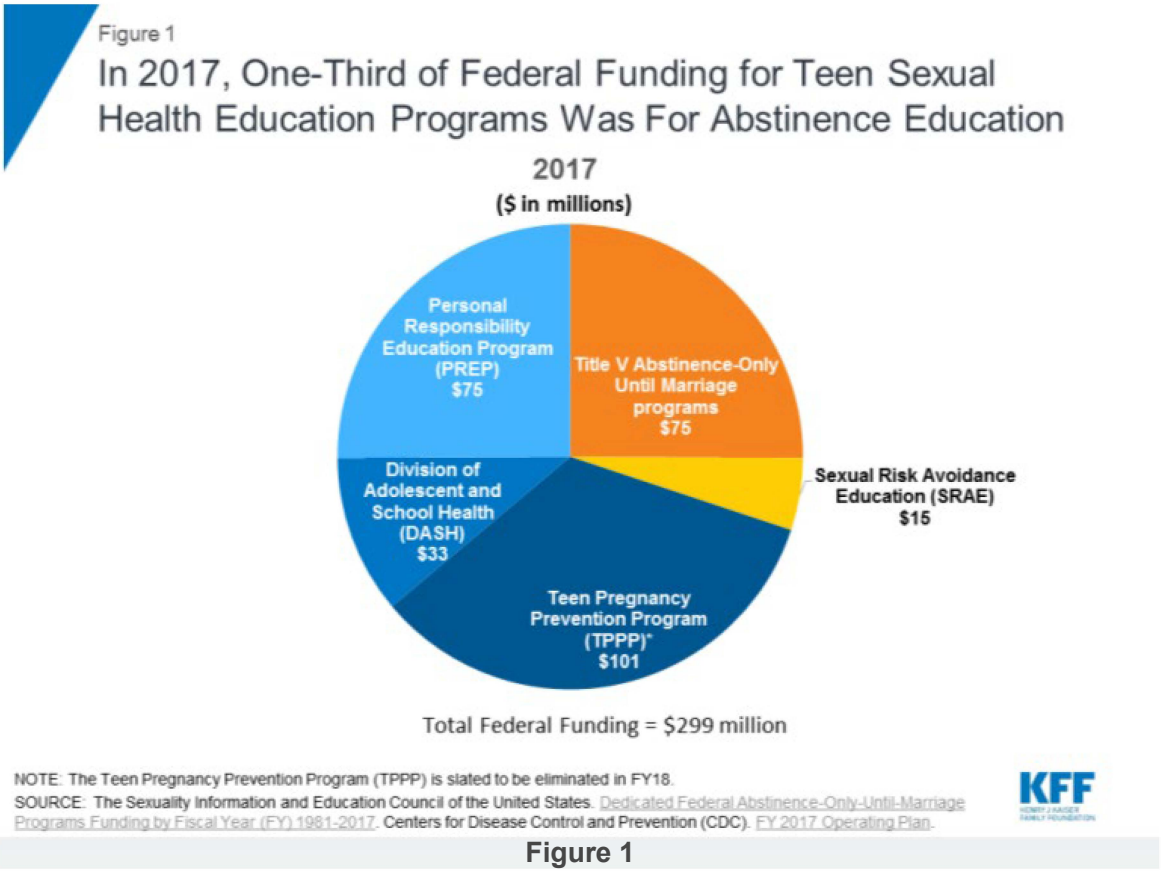


Figure 1

Chapter II

Statistics

Is it supported by data?

On a federal level the Abstinence Only Programs can be supported depending on who you talk to. The topic of sexual education has become another topic of political turmoil between Republicans and Democrats. This is because of the amount of funding allotted and which side the party's member prefers (in viewpoint). An example of this, while not universally true, is that those who are Pro-Life are also Pro-Abstinence education are Republican. In Figure 2 (Below) you can see how the states regulate sexual education [31].

Figure 2: State-Level Sex Education Policy

- **24 states and DC** mandate sex education for youth.
- **37 states** require that when taught sex education must include abstinence, and **26** of which require that it be stressed.
- **13 states** require that the information taught in sex education be medically accurate.
- **18 states and DC** require that when sex education is taught, information on contraception be provided.

SOURCE: Guttmacher Institute. Sex and HIV Education. State Laws and Policies, as of May 1, 2018

Along with the figure above the table below which states have laws or polices regarding Abstinence. Table 4 also rates each state on the four-point scale discussed above.

Table 4

State	Law: Abstinence[1]	Law Level[2]	Laws & Policy Level[3]
Alabama	Yes	3	3
Alaska	-	-	1
Arizona	Yes	2	3
Arkansas	Yes	2	3
California	Yes	1	1
Colorado	Yes	2	2
Connecticut	No	0	0
Delaware	-	-	3
Florida	Yes	3	3
Georgia	Yes	2	2
Hawaii	-	-	3
Idaho	No	0	0
Illinois	Yes	3	3
Indiana	Yes	3	3
Iowa	No	0	0
Kansas	-	-	0
Kentucky	-	-	3
Louisiana	Yes	3	3
Maine	Yes	1	1
Maryland	-	-	0
Massachusetts	No	0	1
Michigan	Yes	1	1
Minnesota	Yes	1	1
Mississippi	Yes	3	3
Missouri	Yes	2	2
Montana	-	-	0
Nebraska	-	-	2
Nevada	No	0	0
New Hampshire	No	0	0
New Jersey	Yes	1	1
New Mexico	-	-	3
New York	-	-	1
North Carolina	Yes	3	3
North Dakota	-	-	-
Ohio	Yes	3	3
Oklahoma	Yes	3	3
Oregon	Yes	1	1
Pennsylvania	Yes	2	3
Rhode Island	Yes	2	3
South Carolina	Yes	3	3
South Dakota	Yes	2	2
Tennessee	Yes	3	3
Texas	Yes	3	3
Utah	Yes	3	3
Vermont	Yes	1	1
Virginia	Yes	2	2
Washington	Yes	2	2
West Virginia	No	0	0
Wisconsin	No	0	1
Wyoming	-	-	-

[1]State laws with (yes) or without (no) an abstinence provision as of 2007 [16].
[2]Level of Abstinence provision in state law as of 2007 [17].
[3]Level of Abstinence provision in state law or other policy as of 2005 [19]; differences to laws[2] are noted in italics.
doi:10.1371/journal.pone.0024658.t002

On the health care level, the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics advocate that adolescents need to discuss contraceptives, sexuality, gender identity, sexual behaviors, and any stigmas heard surrounding the topics listed .The three organizations suggest these discussions for both sexually and non-sexually active adolescents to help protect them as much as possible as well as provide them with medically accurate information [4].

On the parent level there was an overwhelming support for Abstinence-Only education and for the safe-sex instruction. 15% of parents wanted only Abstinence-Only education, 7% wanted there to be no sexual education in school, and 90% of parents found it important for sexual education be taught in school [38]. When it came to the information they wanted the students to know 96% of parents want the curriculum to go over sex/conception, 99% wanted curriculum to include STI's, 91% wanted their students to be taught how to make their own decisions about sex and other related topics without outside influence, 86% wanted the students to know about contraceptive and where to get them, 95% wanted their kids to abstain from sex until they are older, 71% wanted the curriculum to include how to get birth control without their permission, 85% wanted abortion covered, and 73% wanted homosexuality to be discussed.

Pregnancy, Abortion, and STI's

In places where birth control was accessible between the years 1991 and 2003 the pregnancy rate declined by 21% [38].

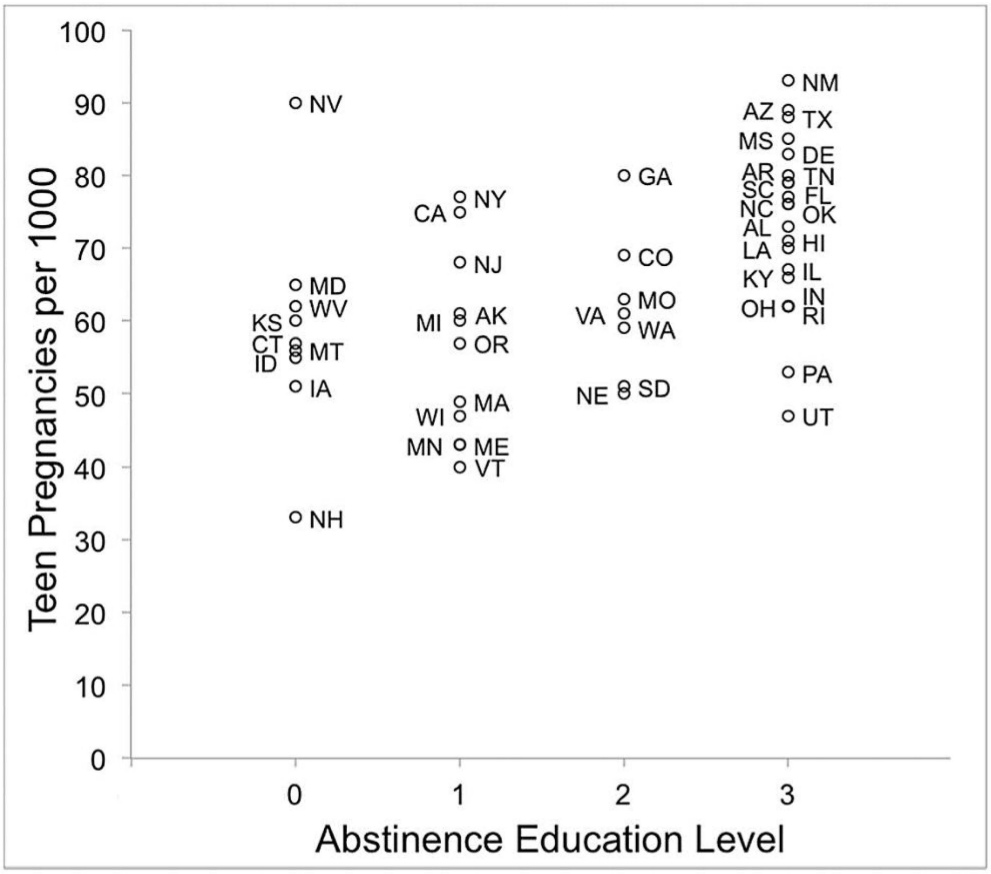


Figure 3

There are over 800,000 pregnancies involving adolescents with 80 of these pregnancies being unplanned. As seen in Figure 3 there is an increase in teen pregnancy as the Abstinence Education Level goes up. When the math is calculated Level 0 had a teen pregnancy average of 58.78 with a standard deviation of 4.96, Level 1 had an average of 56.36 with a standard deviation of 3.94, Level 2 averaged 61.86 with a standard deviation of 3.93, and Level 3 averaged 73.24 with a standard deviation of 2.58 [40]. When comparing Level 0 and Level 3 we see a difference of 14.46 teen pregnancies with the respective standard deviation. Furthermore, in comparison to other developed countries the United States has a significantly higher teenage pregnancy rate (See Table 5) [40]. With comprehensive sexual educational programs there was a decrease by 50%

in the risk of teen pregnancy, an increase of contraceptive purchases, a delay of the first sexual interaction, and a decrease of 60% of incidents where there was unprotected sex [31].

Table 5

International Data	U.S.	France	Germany	Netherlands	Canada	UK
Pregnancy rate (2002–5)	72.2	25.7	18.8	11.8	29.2	41.3^
Birth rate (2006)	41.9	7.8	10.1	3.8	13.3	26.7

Rates are listed as numbers per 1000 girls 15–19 years old,
^15–18 years old [1–4].
doi:10.1371/journal.pone.0024658.t001

As seen in Table 6 there is a positive correlation between high abstinence level and high teen pregnancy contradicting the claims that Abstinence Only sexual education lowers the pregnancy rate among a population.

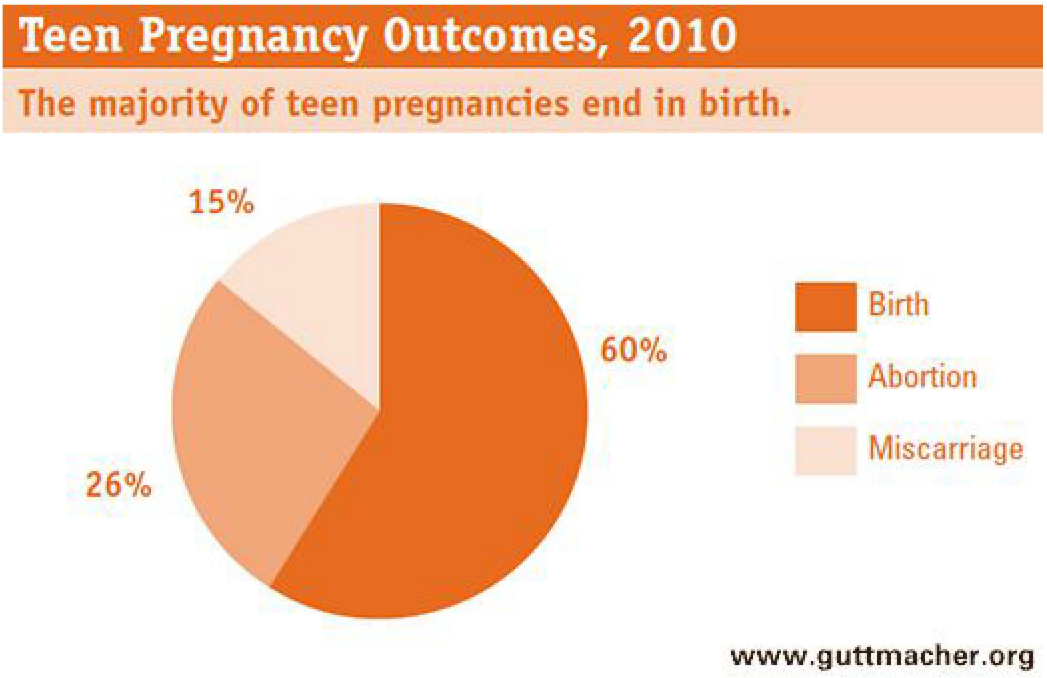
Table 6

Descriptive Statistics by Abstinence Education Level						95% Confidence Interval			
Outcomes	Level	N	Median	Mean	Std. Error	Lower Bound	Upper Bound	Minimum	Maximum
Teen Pregnancies	0	9	57.0	58.78	4.966	47.43	70.23	33	90
	1	11	57.0	56.36	3.943	47.58	65.15	40	77
	2	7	61.0	61.86	3.931	52.24	71.47	50	80
	3	21	76.0	73.24	2.589	67.84	78.64	47	93
	Total	48	62.5	65.00	2.064	60.85	69.15	33	93
Teen Abortions	0	9	11.0	15.78	2.681	9.6	21.96	9	28
	1	11	16.0	20.27	3.069	13.43	27.11	10	41
	2	7	15.0	13.57	2.010	8.65	18.49	6	20
	3	21	12.0	14.86	1.306	12.13	17.58	6	27
	Total	48	15.00	16.08	1.096	13.88	18.29	6	41
Teen Births	0	9	35.2	34.82	3.316	22.8	41.5	18	50
	1	11	26.5	28.43	1.950	24.08	32.77	19	39
	2	7	40.0	39.29	2.765	32.52	46.05	31	53
	3	21	49.1	47.43	2.197	42.85	52.01	30	62
	Total	48	38.5	39.52	1.687	36.13	42.92	18	62

Based on 2005 data for all states except North Dakota and Wyoming, N = number of states.
doi:10.1371/journal.pone.0024658.t003

When pregnancy occurs, there are three main choices for women. The first choice is to carry the fetus to term and keep the baby. The second choice is to carry the fetus to term and adopt the child out or place the child into the Foster Care System. The final choice is abortion. Although there are three choices for teen mothers to choose from 60% of them choose to carry the baby to term and 26% decide to have an abortion (see Figure 4). In spite of the majority of teen pregnancies ending in birth, it has been shown that abortion has fewer health risks and does not appear to have the and temporary and/or permeant affects that can result from bearing a child. It is shown that the pregnancy related deaths from 1991 to 1999 was 11.8 deaths per 100,00 births, while when abortion became legal in 1980 the mortality rate dropped showing that from 1980 to 1997 there was only one death per 100,000 legal abortions[32, 33,38].

Figure 4



Nothing is 100% effective in preventing STI's, not even abstinence. STI's are not always spread through vaginal or anal sex, but can also be spread through kissing, oral sex, and any other exchange of fluids [21,38]. Some STI's cannot be treated through antibiotics or steroids. Some STI's can cause a tubal pregnancy, fetal or infant death, cervical cancer, chronic pelvic pain, and infertility regardless if medication is consumed or not. Each STI has their own set of symptoms but five of the most common STI's are unnoticeable and can be asymptomatic.

It has been estimated that 50% of new Human Immunodeficiency Virus (HIV) infections are from individuals under 25 and 25% of those are from individuals under 22 years old [14,33,38] (Figure 4 and Figure 5). HIV is one of the main five STI's that can be unnoticeable. The only way for an individual to know that they have HIV is if they are tested (see Figure 6). Once the individual gets a positive test they will immediately get put onto medication. This is because if HIV is not treated it turns into AIDS which is fatal. Specifically, in Texas, there has been a large effort to censor all information about contraceptives and HIV/AIDS. They are doing this by removing the information from textbooks and restrict educational professionals from discussing or gaining information about HIV/AIDS [8,38]. Although HIV/AIDS is prevalent in adolescents many do not know the risks of the infection. This causes health companies to make graphics to post to social media along with displaying them in public places in the hopes that someone who did not know the information can get the knowledge and be precautious (See Figure 4, 5, 6, and 7).

Figure 5

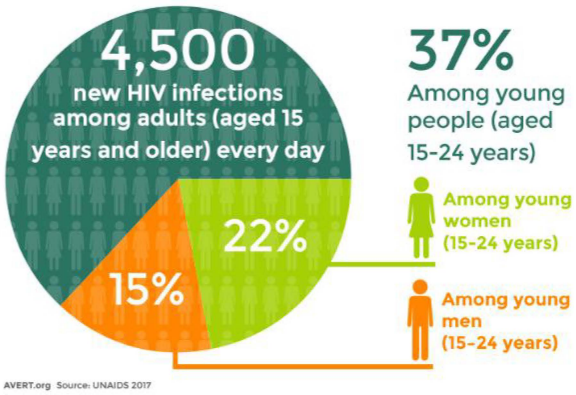


Figure 6

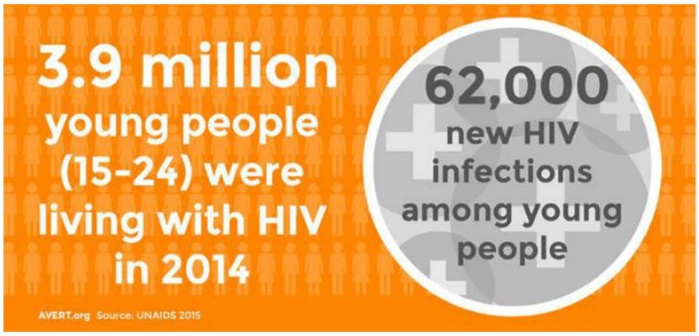
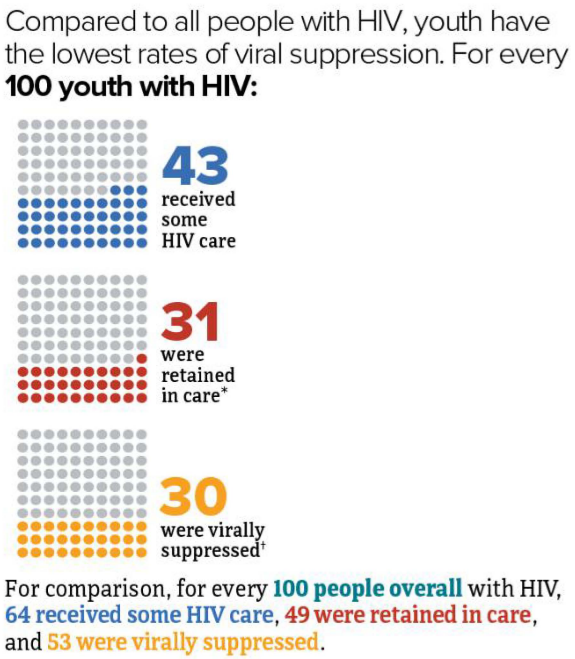


Figure 7

Figure 8



Human Rights violation

One of the main standpoints of the Abstinence is to avoid providing information regarding contraceptives to adolescents. When these programs restrict access to information/materials regarding safe-sex practices and contraception they are restricting the basic human right to have access to the highest attainable standard of health both through receiving knowledge on the topics and getting the medical guidance from a health care professional [38]. The idea that this is a basic human right is not exclusive to the United States, as seen through the multiple international treaties that are currently in effect. These treaties specify that everyone has a right to "seek, receive, and impart information and ideas of all kinds" meaning that everyone should have access to any material regarding safe-sex practices, STI's, and contraceptives and should be able to get instructed on these topics without any censoring or bias. These provisions were set into

place by the U.N. Committee on the Rights of the Child at the Convention on the Rights of the Child. This committee is responsible for overseeing the monitoring the implementation of the provisions set in place. Another act that is centered around the Abstinence-Only education's viewpoint of contraception is Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Article 12 requires governments to take essential steps to prevent, control, and provide treatment of epidemic diseases. The U.N. Committee on Economic, Social, and Cultural Rights is responsible for implementing all provisions set by ICESCR. The provisions in Article 12 are in place to attempt to slow down and eliminate the spread the global epidemic of HIV/AIDS See Figure 8 and Figure 9) [38].

Figure 9

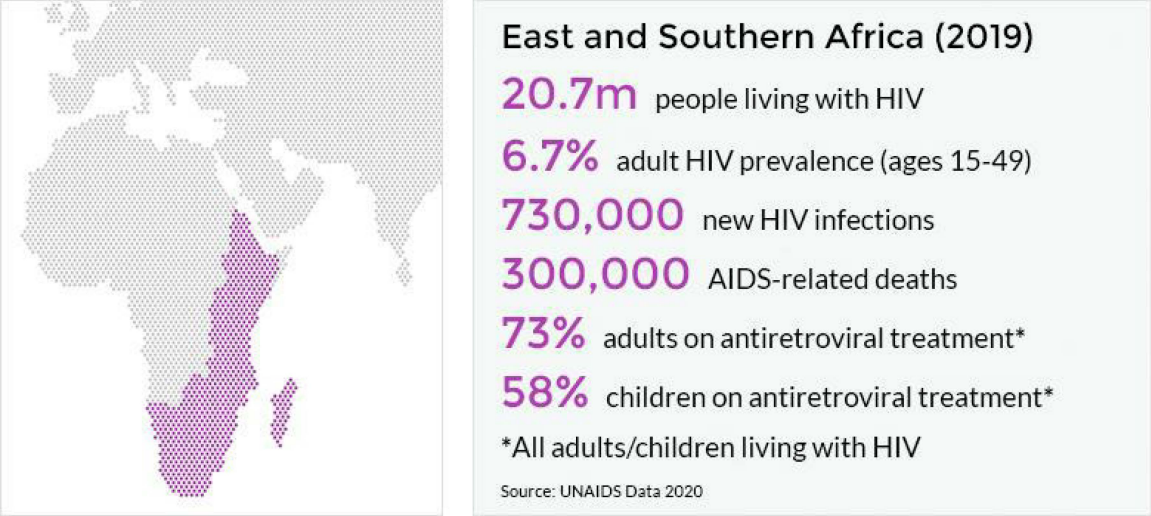
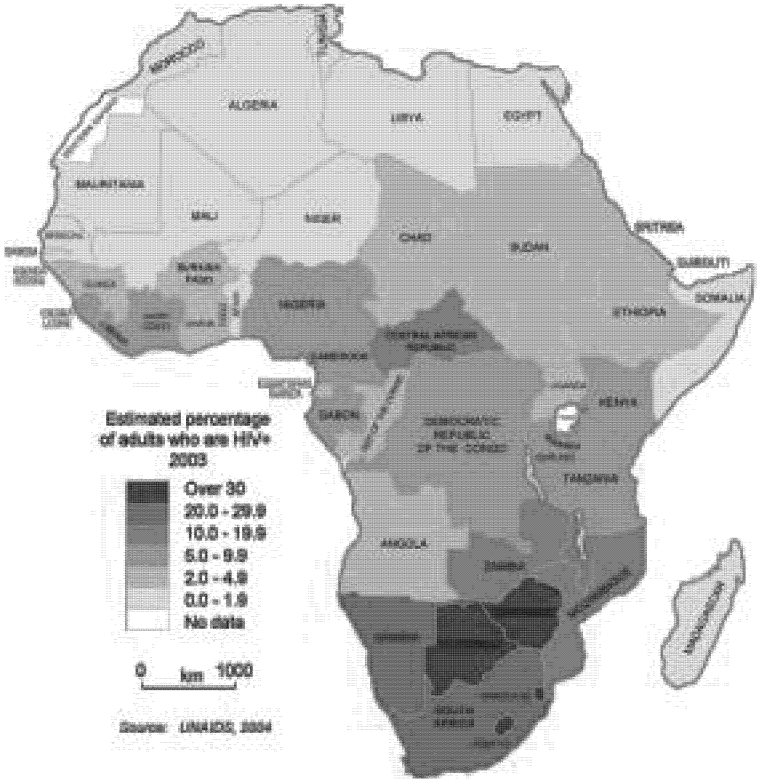


Figure 10



With comprehensive sexual education adolescents will have guidance through the process of obtaining knowledge on the topic and learn how to keep themselves safe. If these adolescents understand the risks and precautions needed to stay safe, then the numbers of those infected will drop.

Another way that Abstinence-only programs violates human rights is by the lack of and restriction of LGBT topics. There is approximately 2.5% of high school students who identify as part of the LGBT community (this statistic does not involve students who are exploring the topics associated with the LGBT community)[38]. The Abstinence only programs do not provide adequate information regarding any of the LGBT topics,

and programs under Section 510 explicitly prohibit the subject(s). The programs that do discuss contraception discuss it with a focus on preventing pregnancy and a secondary focus on preventing STI's [38]. Due to this many gay or lesbian youth do not use protection causing a spread of STI's, both genital and oral, to be spread around the community.

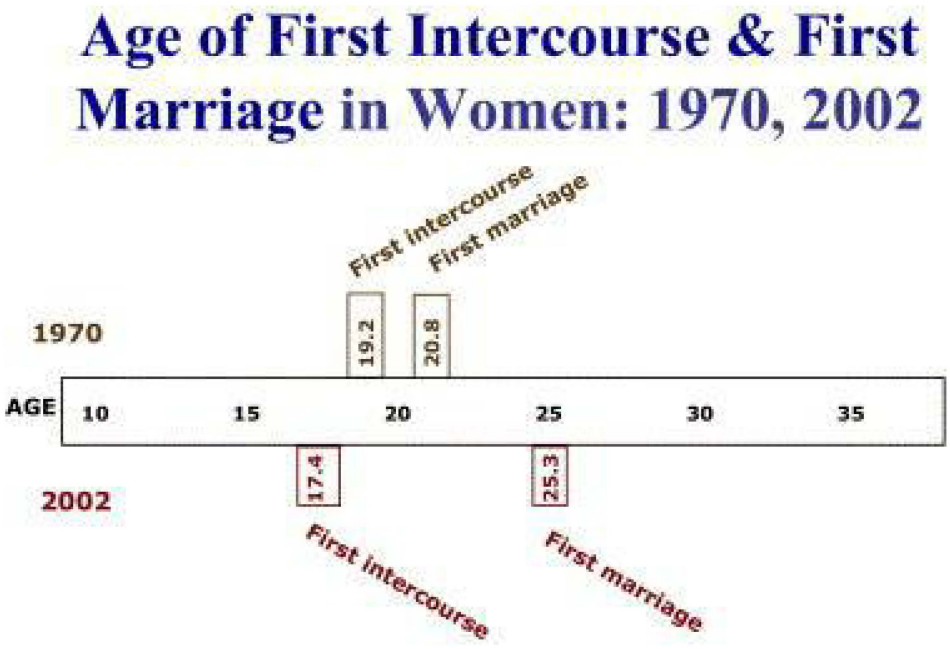
Chapter III

Analysis

Effects

The goal of Abstinence Only Programs is to have adolescents to prolong the first time they have intercourse to a later time or in most cases until marriage. While this seems like it works statistics shows that since 1970 the difference the age of first intercourse and first marriage has increased significantly (Figure 10). This shows that although abstinence only programs can delay it in some cases, the majority of adolescents do not delay the time they first have intercourse [38]. This statement can be proven with a nine-year study that observed four Abstinence-only programs and concluded that the program did not affect the sexual behavior of the students [38,40].

Figure 11



There are multiple arguments made by those who support Abstinence Only Programs. The first argument made by those who support Abstinence Only Programs is that studies show that sexual activity at a younger age is caused by pre-existing mental health issues and will have an a detrimental influence on the adolescents mental health (does not matter if there is a pre-existing condition), but there is no evidence to prove this claim. There seems to be data showing that early sexual activity/pregnancy can be associated with traumatic childhood events. Some of these events could include sexual abuse, conduct disorders, substance abuse, and toxic environments. Another argument is that when intercourse is delayed until marriage that the individual has a higher resiliency, sexual enjoyment, and/or increased sexual function though there are not any studies proving or disproving this claim. The third claim is that there will be severe psychological trauma if the woman decides to have an abortion. This claim has been disproven by countless studies showing that reports of distress post-abortion is lower than the pre-abortion rates. When these studies looked into the long term affects they found that women who had abortions had the same or lower rates of psychological rates and appear to have an improved psychological function at the one-to-two-year checkup post-abortion [19,26,29,32,33,38].

The effects of teen pregnancy affect both the mother and the child. It was found that mothers under 19 are more likely to receive adverse social and health consequences then mothers who gave birth after 19. Along with this, the children of these young mothers have been shown to perform poorly socially and in health in comparison to their peers who were mothered by older women. Furthermore, a study concluded that the

lower birth rates from teen pregnancy directly lead to the decline of child poverty and single-parent families throughout the 1990s [19,38].

These programs can also highly affect an adolescent's mental health and self-confidence. For students who have already participated in sexual activities (consensual or not) this can make them see themselves as less than others. They can think of themselves as dirty, unwanted, unworthy, or even a whore/slut (especially those who were forced into their sexual experiences). It can also cause a feeling of guilt when they start participating in intercourse [38].

There is also a large effect on LGBT youth who participate in Abstinence Only Programs. Although one in every ten adolescents struggle with LGBT topics the Abstinence Only Program restricts the distributing information regarding the LGBT community including definitions, safe-sex practices, and the community itself. This lack of knowledge can cause ignorance with some of the students which can lead to Homophobia. Homophobia in social or school can create an environment of bullying for those who appear to be a part of the LGBT community. This can cause the student (victim) to develop mental health troubles including depression, feelings of self-harm and/or suicide, anxiety, trauma based disorders, feelings of loneliness and/or isolation, development of substance abuse, problems controlling their anger which can lead to acts of violence or outbursts, along with in increased want do participate in sexual activities which could lead to STIs including HIV infections. In the figures below (Figures 12-14) there are multiple different statistics supporting the above statement. An additional factor that these programs often send a homophobic message to the students they teach. The backing behind this belief in America is often couched in religion. Even though the

majority of public schools are non-religious this ideal is still taught in conjunction with the Abstinence Only Program regardless of the school [20,30,38,45].

Figure 12

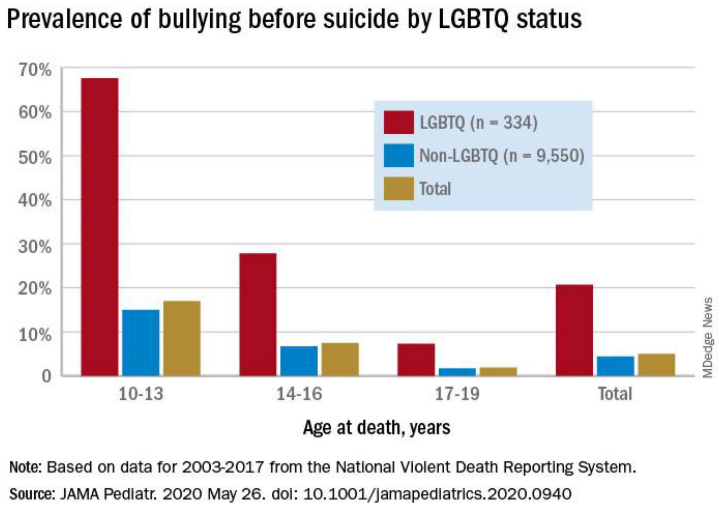


Figure 13

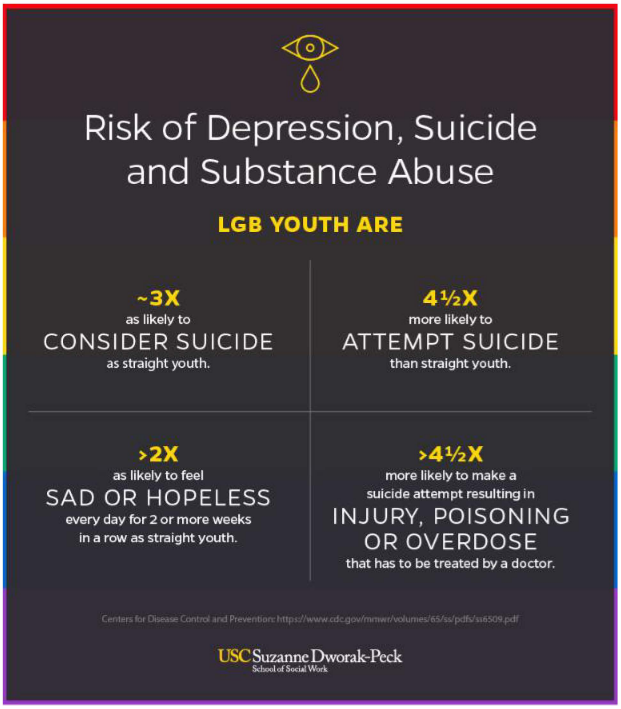


Figure 14

Figure 15

As mentioned previously, other countries have laws addressing Abstinence Only Programs but how the United States navigates the topic also affects other countries. An example of this is how the United States policies have affected the global HIV/AIDS prevention efforts. America has PEPFAR which is an emergency plan for AIDS relief centered around Africa, the Caribbean, and Asia. The Abstinence Only movement has led to the United States allotting a minimum of 33% of the previously mentioned fund towards Abstinence Only programs in the previously mentioned countries. These programs have been scrutinized by many groups for teaching misinformation, censoring information including HIV/AIDS, information, emphasizing abstinence, and have slowing been reducing access to contraception [38].

Conclusion

There are many arguments for both sides, but from my research supporting evidence is for the Pro-Comprehensive sexual education side of the argument. Sexual education affects not only the student but the entire community. Sexual Education can teach safe-sex practices, contraception, topics related to pregnancy, STI/HIV curriculum, puberty in depth, and LGBT topics. Without comprehensive sexual education there is an increased chance of teen pregnancy, negative mental impacts on adolescents, and increased spread of STIs (From treatable to fatal). With comprehensive sex education we see poverty rates go down, lower abortion rates (legal), and lower birth related deaths. Us as adults need to advocate for the children in our community if we want to see any change.

REFERENCES

1. Abma, Joyce C., et al. “Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002.” *Johns Hopkins University*, US Center for Health Statistics, 1 Jan. 2004, jhu.pure.elsevier.com/en/publications/teenagers-in-the-united-states-sexual-activity-contraceptive-use--5.
2. “Abstinence-Only-Until-Marriage Policies and Programs: An Updated Position Paper of the Society for Adolescent Health and Medicine.” *Journal of Adolescent Health*, vol. 61, no. 3, 2017, pp. 400–403., doi:10.1016/j.jadohealth.2017.06.001.
3. Adler, Nancy E., et al. “Abortion among Adolescents.” *American Psychologist*, vol. 58, no. 3, Mar. 2003, pp. 211–217., doi:10.1037/0003-066x.58.3.211.
4. “American Adolescents' Sources of Sexual Health Information.” *Guttmacher Institute*, 3 Jan. 2019, www.guttmacher.org/fact-sheet/facts-american-teens-sources-information-about-sex.
5. Anda, R. “Adverse Childhood Experiences and Risk of Paternity in Teen Pregnancy.” *Obstetrics & Gynecology*, vol. 100, no. 1, July 2001, pp. 37–45., doi:10.1016/s0029-7844(02)02063-x.
6. Adler, N E et al. “Psychological factors in abortion. A review.” The American psychologist vol. 47,10 (1992): 1194-204. doi:10.1037//0003-066x.47.10.1194
7. Bearman, Peter S., and Hannah Brückner. “Promising the Future: Virginity Pledges and First Intercourse.” *American Journal of Sociology*, vol. 106, no. 4, 2001, pp. 859–912., doi:10.1086/320295.

8. Breuner, Cora C., and Gerri Mattson. “Sexuality Education for Children and Adolescents.” *Pediatrics*, vol. 138, no. 2, 2016, doi:10.1542/peds.2016-1348.
9. Brindis, Claire D, and Mary A Ott. “Adolescents, Health Policy, and the American Political process11The Full Text of This Article Is Available via JAH Online at Http://Www.elsevier.com/Locate/Jahonline.” *Journal of Adolescent Health*, vol. 30, no. 1, 30 Jan. 2002, pp. 9–16., doi:10.1016/s1054-139x(01)00316-0.
10. Brückner, Hannah, and Peter Bearman. “After the promise: the STD consequences of adolescent virginity pledges.” The Journal of adolescent health : official publication of the Society for Adolescent Medicine vol. 36,4 (2005): 271-8. doi:10.1016/j.jadohealth.2005.01.005
11. Content Source: HIV.govDate last updated: June 30, 2020. “U.S. Statistics.” *HIV.gov*, 5 Nov. 2020, www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.
12. Curran, J., et al. “Epidemiology of HIV Infection and AIDS in the United States.” *Science*, vol. 239, no. 4840, 1988, pp. 610–616., doi:10.1126/science.3340847.
13. CWB. “HIV/AIDS in Africa.” *CWB Cameroon Autumn 2012*, 12 Sept. 2012, cwbblogs.com/cameroon12/2012/09/13/hivaids-in-africa/.
14. Darroch, Jacqueline E., et al. “Changing Emphases in Sexuality Education in U.S. Public Secondary Schools, 1988-1999.” *Family Planning Perspectives*, vol. 32, no. 5, 2000, p. 204., doi:10.2307/2648173.
15. DE;, Schuster MA;Bell RM;Kanouse. “The Sexual Practices of Adolescent Virgins: Genital Sexual Activities of High School Students Who Have Never Had

Vaginal Intercourse." *American Journal of Public Health*, U.S. National Library of Medicine, 7 Oct. 2011, pubmed.ncbi.nlm.nih.gov/8916522/.

16. *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: a Global Review 2015*. UNESCO, 2015.
17. Garofalo, R., et al. "The Association Between Health Risk Behaviors and Sexual Orientation Among a School-Based Sample of Adolescents." *Pediatrics*, vol. 101, no. 5, 1 May 1998, pp. 895–902., doi:10.1542/peds.101.5.895.
18. Garofalo, Robert, et al. "Sexual Orientation and Risk of Suicide Attempts Among a Representative Sample of Youth." *Archives of Pediatrics & Adolescent Medicine*, vol. 153, no. 5, 1999, doi:10.1001/archpedi.153.5.487.
19. Goodson, Patricia, et al. "Defining Abstinence: Views of Directors, Instructors, and Participants in Abstinence-Only-Until-Marriage Programs in Texas." *Journal of School Health*, vol. 73, no. 3, 9 Oct. 2009, pp. 91–96., doi:10.1111/j.1746-1561.2003.tb03579.x.
20. "Growing Up LGBT in America: View and Share Statistics." *HRC*, www.hrc.org/view-and-share-statistics.
21. Haignere, Clara S., et al. "Adolescent Abstinence and Condom Use: Are We Sure We Are Really Teaching What Is Safe?" *Health Education & Behavior*, vol. 26, no. 1, 26 Feb. 1999, pp. 43–54., doi:10.1177/109019819902600105.
22. Haskins, Ron, and Carol Statuto Bevan. "Abstinence Education under Welfare Reform." *Children and Youth Services Review*, vol. 19, no. 5-6, 1997, pp. 465–484., doi:10.1016/s0190-7409(97)00028-5.

23. “History of Sex Education in the U.S.” *Planned Parenthood*, Nov. 2016, www.plannedparenthood.org/uploads/filer_public/da/67/da67fd5d-631d-438a-85e8-a446d90fd1e3/20170209_sexed_d04_1.pdf.
24. “HIV Among Youth.” *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 18 May 2020, www.cdc.gov/hiv/group/age/youth/index.html.
25. Kirby, Douglas B. “The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior.” Sexuality Research and Social Policy, vol. 5, no. 3, 2008, pp. 18–27., doi:10.1525/srsp.2008.5.3.18.
26. Lindberg, Laura Duberstein, et al. “Changes in Adolescents' Receipt of Sex Education, 2006–2013.” *Journal of Adolescent Health*, vol. 58, no. 6, 2016, pp. 621–627., doi:10.1016/j.jadohealth.2016.02.004.
27. Mann, Posted By Katy. “Just Be Kind: How to Stop Bullying Related to Sexual Orientation and Gender Identity.” *Indy with Kids*, 21 June 2016, indywithkids.com/just-kind-stop-bullying-related-sexual-orientation-gender-identity/.
28. Paik, Anthony, et al. “Broken Promises: Abstinence Pledging and Sexual and Reproductive Health.” *Journal of Marriage and Family*, vol. 78, no. 2, 2016, pp. 546–561., doi:10.1111/jomf.12279.
29. Pinkerton, Steven D. “A Relative Risk–Based, Disease-Specific Definition of Sexual Abstinence Failure Rates.” *Health Education & Behavior*, vol. 28, no. 1, 28 Feb. 2001, pp. 10–20., doi:10.1177/109019810102800102.

30. Publish date: May 27, 2020, and Richard Franki. “Suicide Often Associated with Bullying in LGBTQ Youth.” *MDedge*, 27 May 2020, www.mdedge.com/pediatrics/article/222769/mental-health/suicide-often-associated-bullying-lgbtq-youth.
31. Published: Jun 01, 2018. “Abstinence Education Programs: Definition, Funding, and Impact on Teen Sexual Behavior.” *KFF*, 1 June 2018, www.kff.org/womens-health-policy/fact-sheet/abstinence-education-programs-definition-funding-and-impact-on-teen-sexual-behavior/.
32. Quinton, Wendy J., et al. “Adolescents and Adjustment to Abortion: Are Minors at Greater Risk?” *Psychology, Public Policy, and Law*, vol. 7, no. 3, 7 Sept. 2001, pp. 491–514., doi:10.1037/1076-8971.7.3.491.
33. Rosenberg, P S. “Scope of the AIDS epidemic in the United States.” Science (New York, N.Y.) vol. 270,5240 (1995): 1372-5. doi:10.1126/science.270.5240.1372
34. Roser, Max, and Hannah Ritchie. “HIV / AIDS.” *Our World in Data*, 3 Apr. 2018, ourworldindata.org/hiv-aids.
35. Samoldfield. “Teen Pregnancy Is a Good Thing. Let's Embrace It.” *In the Trenches*, 12 Nov. 2015, samoldfield.wordpress.com/2015/11/12/teen-pregnancy-is-a-good-thing-lets-embrace-it/.
36. Santelli, John S. “Medical Accuracy in Sexuality Education: Ideology and the Scientific Process.” *American Journal of Public Health*, vol. 98, no. 10, 2008, pp. 1786–1792., doi:10.2105/ajph.2007.119602.

37. Santelli, John S., et al. “Contraceptive Use and Pregnancy Risk Among U.S. High School Students, 1991–2003.” *Guttmacher Institute*, 6 Dec. 2016, www.guttmacher.org/journals/psrh/2006/contraceptive-use-and-pregnancy-risk-among-us-high-school-students-1991.

38. Santelli, John, et al. “Abstinence and Abstinence-Only Education: A Review of U.S. Policies and Programs.” *Journal of Adolescent Health*, vol. 38, no. 1, 14 Oct. 2005, pp. 72–81., doi:10.1016/j.jadohealth.2005.10.006.

39. Smith, Thomas E., et al. “Measurement in Abstinence Education.” *Evaluation & the Health Professions*, vol. 26, no. 2, 26 June 2003, pp. 180–205., doi:10.1177/0163278703026002004.

40. Stanger-Hall, Kathrin F., and David W. Hall. “Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.” PLOS ONE, Public Library of Science, 14 Oct. 2011, journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0024658.

41. Underhill, Kristen, et al. “Sexual Abstinence Only Programmes to Prevent HIV Infection in High Income Countries: Systematic Review.” *Bmj*, vol. 335, no. 7613, 2007, p. 248., doi:10.1136/bmj.39245.446586.be.

42. Unknown. “Young People, HIV and AIDS.” *Avert*, 23 Apr. 2020, www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people.

43. Weinstock, Hillard, et al. “Sexually Transmitted Diseases Among American Youth: Incidence and Prevalence Estimates, 2000.” Perspectives on Sexual and Reproductive Health, vol. 36, no. 1, 2004, pp. 6–10., doi:10.1363/3600604.

44. Zabin, L S et al. “When urban adolescents choose abortion: effects on education, psychological status and subsequent pregnancy.” Family planning perspectives vol. 21,6 (1989): 248-55

45. 15, posted on June. “INFOGRAPHICS: ‘Forward Thinking Campaign’ Shares the Risks for LGBTQ Youth Still Today.” *Campus Pride*, 21 June 2017, www.campuspride.org/forwardthinking/

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High School Diploma June 3, 2018
Clear Brook High School
Friendswood, TX
GPA: 3.68/4.0

Experience:

Greene Family Camp, Bruceville, TX Summer 2017 – Present
Avodah and Counselor

- Provided assistance to fellow employees with the management of their campers and programs.
- Ensured the safety of approximately 100 campers from ages of six to twelve for the duration of the summer and year-round events.

Clear Creek Independent School District October 2016 – June 2018
Teacher-in-training

- Planned, prepared, and delivered instructional activities that facilitated active learning experiences.
- Instructed and monitored students with the use of learning materials and equipment.
- Performed duties including student support, counseling students with academic problems and providing student encouragement.

Houston Congregation of Reform Judaism, Houston, TX August 2016 – August 2017
Ozrim

- Educated students ages three – twelve over the history of the Jewish people.
- Ensured the safety of all children inside of the temple for the duration of school hours.

Skills:

- American Sign Language – Fluent
- Leadership skills
- Communication skills

Accomplishments:

- Bowers Honors College Ambassador March. 2020 - Present
- Alpha Omicron Pi – Member Oct. 2018 – Present
- Alpha Lambda Delta – Member Jan. 2019 – Present
- Kappa Delta Pi – Member 2019 – Present
- Golden Key International Honor Society - Member 2020 - Present
- Phi Alpha Theta – Member 2020 - Present
- STEM Education International Conference 2020- Speaker Nov. 2020
- Google Teacher Certified Nov. 2020
- CPR/AED/First aid certified 2019