Author: **Daschel, Rebecca, L**
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STUDENT:

NAME Rebecca L. Daschel **DATE:** 05/15/2012

ADVISER:

NAME Dr. Amy Gillett **DATE:** 05/15/2012

This section for MS Plan A Thesis or EdS Thesis/Field Project papers only
Committee members (other than your adviser who is listed in the section above)

1. **CMTE MEMBER'S NAME:** Dr. Kimberly Martinez **DATE:** **5/15/12**

2. **CMTE MEMBER'S NAME:** Dr. Christine Peterson **DATE:** **5/15/12**

This section to be completed by the Graduate School
This final research report has been approved by the Graduate School.

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Daschel, Rebecca L. ***The Effectiveness of Sex Education Programs in the Schools***

Abstract

This paper examined the research of sexual education programs in the schools. It also allowed for a better understanding of what students are being taught and what has shown to be effective. However, there are numerous matters that revolve around the topic. Currently, teenage pregnancies and sexually transmitted diseases are high; however, it is important to understand the education that each teenager receives to better understand the statistics. Abstinence-only and comprehensive sexual education programs are the two main curriculums taught in the schools. There are specific reasons regarding why each program is taught in each school. Furthermore, there are a variety of different programs besides the main two that have shown to be effective for those involved. Each school has a different outlook and direction on the subject of sexual education programs; therefore, it is crucial to understand what, where, and why it is being offered.

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University of Wisconsin-Stout

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TABLE OF CONTENTS

……Page

ABSTRACT……..…….…ii

Chapter I: Introduction……...……..…1

Statements of the Problem…..……...…….....….4

Purpose of the Study…..…..……..……...5

Research Questions……..…….……..…5

Definition of Terms……...…….….5

Assumptions/Limitations of Study.....6

Methodology……..……..……..…7

Chapter II: Literature Review……..……...……..…….8

What is being taught……..……..……..……..8

What is effective…….……..…….14

Funding…….……..……...……18

Critical Analysis…….……...…….22

Recommendations……..26

Conclusion……...……..27

Chapter III: Methodology…….……..…….28

Survey Instrument……...……...28

Procedures……..……..……..29

Data Analysis…….……...…….29

Limitations.....29

Chapter IV: Results……...31

Results……...31

Summary of Research Questions…….....……...…34

Chapter V: Discussion, Conclusions, and Recommendations…….....……...36

Discussion of Findings….....36

Conclusions.....….....37

Implications for Practice……..…….39

Implications for Further Research.....40

References…….……...41

Appendix A: Consent to Participate in UW-Stout Approved Research.....44

Appendix B: Survey.....46

Appendix C: Survey Response Tables.....48

Chapter I: Introduction

Many issues surround the topic of sexual education programs in the schools. These questions can range from what will be taught to how frequently it should be taught. Today's teenagers reach puberty at an earlier age, but marry at a later age. One study found that by age 12, 12 percent of U.S. students had already engaged in vaginal sex, 7.9 percent in oral sex, and 6.5 percent in anal sex (Health News, 2009). These statistics are alarming because youth who start having sex before the age of 14 are more likely to have multiple partners throughout their lifetime. One study found that approximately eight in ten males and seven in ten females are sexually experienced by the age of 19 (Guttmacher, 1981). One survey revealed that 44% of girls and 64% of boys reported that they were sexually active by their 18th birthday. By age 15, seven in ten boys and five in ten girls have had sexual intercourse (Masserman & Uribe, 1989). According to Campos (2002, p. 6), condoms tend to have a 31% failure rate. Condoms also offer little protection from chlamydia and human pappilloma virus (HPV). "Adolescents themselves appear to hold values and attitudes consistent with responsible sexual conduct, but sexually experienced teens usually indicate that the best age for first intercourse is older than they were when they began having sex" (Somers & Paulson, 2000, p. 630).

Youth deserve the right to have access to information and knowledge about making healthy and responsible decisions about their sexuality. However, it is not all as readily available as one would hope. If there is information available, it may be narrowly stated, when it should be providing the depth needed for healthy decision making. "In the USA, federally funded abstinence-only-until-marriage education programs must adhere to a strict eight-point definition, which requires them to teach that, sexual activity outside of marriage is likely to have harmful

psychological and physical effects" (Mabray & Labauve, 2002, p. 31). Because of this approach, it could be suggested that this makes the programs narrow in focus and therefore problematic.

According to McKeon (2006), there are currently as many as 850,000 pregnancies that teens are experiencing, along with 9.1 million sexually transmitted infections a year. "It is also estimated that more than half of all new HIV infections occur before the age of 25 and most are acquired through unprotected sexual intercourse" (APA, 2005, p. 1). Unfortunately, many of these infections occur because teenagers have not acquired the knowledge on how to practice healthy sexual behaviors and make healthy choices. Both comprehensive sex education and abstinence-only programs delay the beginning of sexual activity (APA, 2005).

According to researchers Mabray and Labauve (2002), 55% of districts utilizing a sexual education policy in the southern USA have an abstinence-only policy. Among the seven in ten U.S. school districts having a district-wide policy to teach sex education, 86% require that abstinence is stressed, 51% have an abstinence-plus approach, and 35% have an abstinence-only-until-marriage policy (Mabray & Labauve, 2002). "In one-third of the districts with the abstinence-only approach, information about contraception is severely limited or entirely prohibited" (Mabray & Labauve, 2002, p. 33). Furthermore, 14% have a comprehensive curriculum addressing abstinence as one of numerous options in the preparation of adolescents to help them become responsible enough to make healthy sexual decisions.

There are several suggestions as to what should be taught in a curriculum in regards to sexual education. For example, psychologist Maureen Lyon, Ph.D. (2005) reported that abstinence-only programs showed an unintended consequence of unprotected sex at first intercourse and during later sexual activity. She also indicated that abstinence-only programs increased "the risk of these adolescents for pregnancy and sexually transmitted illnesses,

including HIV/AIDS" (APA, 2005, n.p.). Other psychologists have found that comprehensive sexual education programs are the most effective in keeping adolescents who are sexually active, free of disease (APA, 2005). These programs provide students with healthy information, encourage abstinence, promote condom use for those who are sexually active, encourage fewer sexual partners, educate about the importance of early identification and treatment of sexually transmitted diseases, and teach sexual communication skills (APA, 2005).

"It is a common misconception that educational, occupational, social, medical, and economic difficulties experienced by adolescent mothers and their children are the consequence of teen childbirth" (Mabray & Labauve, 2002, p. 32). Another area to look at besides just sexual education is social and economic disadvantages. These two disadvantages can be the causes and consequences of teen childbearing. When only one sexual education program is offered, like abstinence-only-until-marriage, a large percentage of sexually active youth are overlooked (Mabray & Labauve, 2002).

In 1998, 173,252 females aged 15-17 gave birth in the USA and in 1997, 78.2% of the teenage births were out of wedlock (Mabray & Labauve, 2002). "Before the age of 20, four in ten girls become pregnant" (National Campaign to Prevent Teen Pregnancy, 1998, n.p.). Researchers also took a look at teenagers having sexual intercourse across the world. Teens in the USA begin having sex at an average age of 16.3, whereas teens in France begin at 16.6, Germany 17.4, and the Netherlands teenagers wait until 17.7 years of age (Mabray & Labauve, 2002). Unlike the USA, teens in these other countries have fewer partners and the education that they are receiving does not ask them to abstain from sex. Interestingly enough, as discussed above, abstinence-only-until-marriage is the primary curriculum taught in the USA, which has the youngest age of the countries discussed above regarding first onset of sexual intercourse.

There are several programs that have been introduced as a sexual education curriculum. The first one is Project Taking Charge. It is one of the earliest and most well-known abstinence-only-until-marriage sexual education programs. There are two other abstinence-based programs, Postponing Sexual Involvement and Worth the Wait. Also, Teen Outreach and Plain Talk are two successful comprehensive approaches to sexual education that will be discussed as well. These programs and others offered in the U.S. will be discussed more extensively in Chapter II.

Sex education has two goals: to reduce the risks of potentially negative outcomes from sexual behavior (unwanted or unplanned pregnancies or sexually transmitted diseases) and to enhance the quality of relationships. Also, it is important for sexual education to help develop young people's decision making abilities throughout their lifetime. "Sex education that works, by which we mean that it is effective, is sex education that contributes to this overall aim" (Forrest, 2009, n.p.).

Statement of the Problem

Schools use a variety of different programs throughout their health education curriculum. Some of them may be less effective than others. Students are different than those in the 1970's and 1980's. What worked then might not be effective now in 2012. If a program is not working, then a school should implement changes to better their programs to benefit their students. Schools should also be accountable for effective programs that meet the needs of students today. The specific purpose of this study is to gain knowledge on the different sexual education curriculums that are being taught and which ones seem to be more effective for middle school students.

Purpose Statement

The purpose of this investigation is to determine which sexual education programs are being taught in the schools and how effective they are according to middle school-aged students. This will be done by conducting a survey in the Spring of 2012.

Research questions

Research questions are provided below for a foundational knowledge. These questions will be addressed and explored further throughout this investigation.

1. What message is being taught from the sexual education curriculum in the schools?
2. Are curriculums addressing a variety of sexually transmitted diseases?
3. Are students being educated on different forms of contraceptives?
4. Was the topic of puberty appropriately discussed with students and at what age was it being taught in the schools?

Definitions of terms

For clarity of understanding, definitions are provided below. These definitions provide a more in-depth description and will be used throughout the paper.

Abstinence-only-until-marriage - this approach teaches students that abstinence is the only way to prevent teen pregnancy.

Abstinence-plus – this program promotes abstinence as the ideal option for youth and recognizes that they should practice protected sex. It also focuses on reducing one or more sex behaviors that lead to sex.

Comprehensive sexual education - teaches students about contraceptives and practicing safe sex. This approach also teaches students about goal setting and allowing them to explore their values.

Disability and/or Disabilities – may be a physical, cognitive, mental, sensory, emotional, developmental impairment for one person.

Prevention – teaches youth about the actions that stop something from happening.

Sexual education programs - the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships, and intimacy.

Sexually transmitted diseases (STDs) - according to the Mayo Clinic Online (2009), are infections acquired by sexual contact. The organisms that cause sexually transmitted diseases may pass from person to person in blood, semen, or vaginal fluids.

Assumptions and Limitations

The following are possible assumptions.

1. It was assumed that students receiving the survey have received sexual education within their school setting.

2. It was assumed that the students' completing the survey are aware of puberty.

3. It was assumed that the survey would be an adequate measure of students' perceptions regarding their sexual education program.

4. It was assumed that the survey will be answered honestly and returned in a timely fashion.

The following are possible limitations.

1. A possible limitation considered was not every student completing this survey has received sexual education within their school setting.

2. Another limitation of this study is that the technical adequacy, including reliability and validity, of the survey, has not been examined.

3. A limitation of this study would be that only eighth grade middle school students in one district in Minnesota were asked to participate in this survey, therefore, the results should not be generalized to other students and programs in other states.

Methodology

Chapter II is a review of the literature, including what programs are being taught, which curriculums are proving to be effective, who the curriculum is being taught to, and what funding is provided for schools. Chapter III addresses the information related to the methodology of the quantitative study. Chapter IV addresses results from the research conducted, and Chapter V provides a discussion of the results.

Chapter II: Literature Review

Sexual education programs in the schools allow students to acquire knowledge about sexual identity, attitudes and beliefs toward sex, and intimate relationships. Not only is it about acquiring knowledge but it is also informing students about positive choices regarding safe sex and consequences that can affect their behavior both physically and emotionally. Fortunately, it is students' right to sex education because it can benefit them from future problems and challenges, and improve their health. Supporters say that sex education should be considered as fundamental as reading, writing, and math. Schools around the nation teach different approaches to sexual education, which means there is not one proven correct way to teach these programs. Some would debate that students should have information about the physical and emotional changes their bodies will be going through with puberty and if they decide to become sexually active. Others may debate that students should be taught to just not have sex at all. Numerous programs are available commercially today, however, schools have created their own curriculum to meet the needs of their youth in the community. Presently, the different approaches being taught in the schools include: safe sex, abstinence, and a multi-dimensional/comprehensive approach. In this chapter, the following will be discussed: what is being taught in the schools, what is shown to be effective, and funding for the programs.

What is being taught?

There are several programs that are being taught in the schools. They include abstinence-only-until-marriage to comprehensive approaches, with abstinence-only being the primary curriculum. Most abstinence-only programs have been created on a Christian basis and tend to be the most restrictive when it comes to youth having sex. The typical goals of this program tend to be created on the biblical principle that sex outside of marriage is completely wrong and the only

effective method of birth control is to abstain totally from sex until marriage. Another goal of abstinence-only programs is to help prevent emotional damage created by having sex at a young age. According to Campos (2002), he suggested that youth and society desire an abstinence-only lifestyle. According to a study based out of the University of Chicago, researchers surveyed adults and found 68% agreed that premarital sex was invariably wrong. Another study from Emory University found that of 1,000 sexually experienced female youth, approximately 85% expressed a desire to learn how to spoil their partner's sexual advances. In a national tabloid's survey of 1,200 youth and adults, 72% of the youth and 78% of the adults agreed with a particular pro-abstinence message (Campos, 2002). Supporters of abstinence-only programs argue that they are effective and they do work. The program, "Best Friends," was originally created for inner-city girls in Washington, DC. This program includes positive role models for each of the participants and teaches that, through abstinence from sex and drugs, anyone can fulfill their dreams and goals and live a dignified life. They are also taught that having a good support group of friends is also necessary for a successful future, compared to friends who may be self-destructive. Girls also learn to work towards their goals for their future and how to create necessary boundaries when it comes to boy interactions and instead create positive, healthy, nonsexual relationships. The results showed that only 4% of graduates from "Best Friends" had sex by the age of fifteen compared to 63% of girls who had not been a part of the "Best Friends" program. "Moreover, approximately 1% of the "Best Friends" graduates became pregnant as compared with 26% of the girls in the same school system" (Campos, 2002, p. 8). Project Taking Charge is a 6 to 9 week, abstinence-only-until-marriage sexual education program that was established early on and became popular. The message portrayed is to help youth learn to "take charge of their future"(Mabray & Labauve, 2002, p. 34), which would be accomplished by

youth learning to delay sexual activity and other choices that may have high-risk consequences to them. This program was developed in an attempt to prevent teen pregnancy and was aimed at young youth. The program's curriculum was founded on ten values: 1) equality, 2) self-control, 3)respect for others, 4) responsibility, 5) honesty, 6) promise keeping, 7) self-respect or self-esteem, 8) dependability, 9) trustworthiness, and 10) justice and fairness (Mabray & Labauve, 2002). The program consists of three sessions covering five units. Parents are encouraged to attend with their child/adolescent. "The youth are encouraged to participate in a job shadowing exercise in which they visit work sites and interview individuals about their chosen professions. The parent sessions discuss adolescent development, career development, and communication techniques and issues" (Mabray & Labauve, 2002, p. 34). Five years after Project Taking Charge was created and implemented, a second edition was released to include lessons on substance use, diversity, and sexual abuse. It is highly recommended that parents are involved with this program because of the topics covered and the support that adolescents will need.

Similar programs to Project Taking Charge are: Choosing the Best, Worth the Wait, and Postponing Sexual Involvement. According to Mabray and Labauve (2002), Worth the Wait program is a comprehensive abstinence-based program that reaches out to sixth, seventh, and eighth graders. The lectures are sensitive to each grade level. For example, the sixth graders get to watch a video and take surveys demonstrating their sexual knowledge. However, seventh graders are taught information about sexually transmitted diseases, safe-sex, and unhealthy sexual relationships; while eighth graders learn more about anatomical facts, the laws pertaining to sex and the right to say no, and more about sexually transmitted diseases.

Postponing Sexual Involvement is another abstinence-based program offering two units: Human Sexuality and Postponing Sexual Involvement and covering 10 sessions. The curriculum is

based on delaying sexual activity. It was originally created for those youth of color who were at risk for STDs and unplanned pregnancies. It teaches the benefits of delaying sexual activity and includes reproductive health, adolescent development, and birth control. Also, program participants are given scenarios and then role-play ways to resist pressure and conduct themselves responsibly. "In one study of 'Postponing Sexual Involvement,' 24% of program graudates had engaged in sex as compared to 39% who were not included in the program" (Campos, 2002, p. 8).

According to Mabray and Labauve (2002, p. 36), "comprehensive sexual education programs are rare in the USA, but they address the needs of the adolescent in a more complete manner." It is also said that comprehensive sexual education programs teach gender identity, sexual development, affection, intimacy, body image, interpersonal and communication skills and "assists in the exploration of values and goal setting" (Campos, 2002, p. 9) to achieve a lifetime of sexual health. "While teaching abstinence is a part of preventing pregnancy, 'just saying no' may not be effective with sexually active teens" (Van Dorn, 2000, n.p.). Schools in New Mexico now lead the country in teen pregnancies. According to the Washington Independent (2011, n.p.) "New Mexico students are also behind their national peers in sexual education, 77 percent of high school youth were taught about HIV/AIDS in school, compared to the U.S. median of nearly 86 percent." "Comprehensive sexual education is one of the strategies that work to reduce teen pregnancies and STIs" (Washington Independent, 2011, n.p.). Other goals for a comprehensive sexual education program include supporting the abstinence from sex as the best choice for youth; however, the goals are not embedded regarding abstinence-only. To achieve a healthy lifestyle regarding sex, one must acquire a positive and comfortable attitude

towards sex. Among the topics that are covered in a comprehensive sexual education program curriculum are: abortions, masturbation, oral sex, homosexuality, and condoms.

The Multidimensional Sex Education Program was proposed by Mabray and Labauve (2002). This program involves multiple curriculums with specific emphasis on male sexuality and at-risk groups. There are many different dimensions under the at-risk groups that are covered in the Multidimensional Sex Education Program. Dimensions include: lower income families, lack of involvement in schools, lack of performance in school, and number of previous pregnancies per participant in this group. Stage one of the multidimensional approach looks at assessment and goal development. Values and morals differ across cultural groups, therefore, it is important that the interventions used must match the values and morals of each culture. Next, a group of team leaders are selected. These leaders can be parents, teachers, faith leaders, and anyone else in the community. After they are selected as leaders, they undergo an intensive interview, background check, and training process. Once the leaders are cleared, the school district then helps with providing a list of at-risk females and they are invited, along with their parents, to attend the initial orientation for the program. It is important to reach out to the already sexually active teens. "It is also important to understand that no matter how much effort is expended on behalf of the teenagers, some will choose to have sex anyway; this population must be acknowledged and assisted within this program" (Mabray & Labauve, 2002, p. 39).

Step two is the education section, and included in this section are two components. The first component involves the community and concerned parents. The second component involves adolescents attending the same workshops described in step one. These presentations are offered by the community leaders and involve parents, which would mean a better time for these workshops are typically evenings and weekends. "The workshops should utilize handouts,

assorted visual aids, and role-plays in addition to discussion and question/answer formats" (Mabray & Labauve, 2002, p. 40). These are divided into two sections, the health component and the developmental component.

The health component involves physiological facts of development, including how reproduction works, when it occurs, and a lesson about the different organs in our bodies. Also, the topic of STDs is discussed in detail. The presentation should also include contraception methods, pregnancy rates, and the overall goal of safe sex. The developmental component is not as basic as the health component. The importance of peer groups, out-groups, leadership, and self-esteem are presented and discussed in detail. Role-playing, character-driven lessons, and guest speaker activities are some of the techniques that the developmental component uses. "Furthermore, discussion of topics should be conducted to illustrate the difference in quality of life, when a teen possesses each, and the importance of each attribute in development" (Mabray & Labauve, 2002, p. 41). "Sometimes a teen will assent to sexual activate simply due to a lack of knowledge about other options" (National Campaign to Prevent Teen Pregnancy, 1998, n.p.). Role models are also a part of this component. This is part of the community service element and finding an appropriate and reliable role model for a participating teen. This could help in reinforcing healthy behavior in teens. Finally, evaluating the program is helpful to assure the effectiveness of the program so that it can continue. Mabray and Labauve (2002) believed that presenting knowledge in real life situations is easier to grasp and that is what they are hoping teens get out of the multidimensional approach.

Abstinence-plus is a relatively new curriculum that promotes abstinence and still teaches about sexuality. Abstinence-plus and comprehensive sexual education are relatively one in the same. However, the main difference is that abstinence-plus is directed at smaller populations

and works with specifically targeted groups. Participants in this program were taught that in order to avoid STDs, unwanted pregnancies, and AIDS, they must avoid sex; however, they were also taught that protected sex is better than unprotected sex.

What is effective?

Although many school districts offer sex education programs, the time that youth are exposed to the curriculum is limited. "Youth in grades seven through twelve receive an average of six and a half hours of sex education a year, and less than 10 % of all youth receive a comprehensive sex education" (Campos, 2002, p. 21). Schools fail to expose youth to sexual education for a longer time due to a number of reasons. First, there is an assumption that exposing youth to the curriculum may increase their sexual activity. Second, there is a strong need and support to teach the primary academics first and foremost, rather than spending a great deal of time on health. Third, teachers have a low comfort level teaching the curriculum; this can be due to a variety of reasons. Even though youth spend minimal time in the classroom learning about sexual education, they are still learning and exposed to it from parents, peers, media, and personal experiences.

David Campos, the author of Sex, Youth, and Sex Education (2002), stated that supporters like McIlhaney, believe that abstinence-only sex education programs are accomplishing very little to decrease the number of youth who have to contend with an unplanned pregnancy. Research from New Jersey suggested that in an eleven-year period of comprehensive sex education, the rate of youth pregnancy occurring among unwed couples increased from 67.6% to 84%.

According to research by the World Health Organization:

> A review of 35 programs from around the world found that programs teaching only abstinence were less effective than those promoting the delay of sexual intercourse while teaching practices of safe sex, such as contraception and condom use, in delaying sexual intercourse among youth having not experienced sex and at improving the use of contraception among sexually active teens. (cited in Baldo, Aggleton & Slutkin, 1993, p. 33)

Research conducted by the World Health Organization recommended that sexual education programs include lessons on safer sexual behavior, along with abstinence, rather than just abstinence. Abstinence-only programs do increase the knowledge of youth and change their behavior to a certain extent; however, these changes can be short.

> Comprehensive sex education supporters are not necessarily joyful or complacent about the current facts but instead are cautiously optimistic when studies suggests that the rate of sex among youth has decreased, the rate of youth using contraceptives is up, and births to youth have decreased. (Campos, 2002, p. 10)

Supporters of comprehensive sex education programs believe that abstinence-only programs use scare tactics and unscientific approaches to keep youth from engaging in sexual behavior. Even though abstinence education programs are more accepted by schools, it seems that there are still high percentages of young teens who become pregnant. According to the American Foundation for AIDS Research (2005, n.p.), abstinence programs are taught more in the schools because "no highly effective sex education or HIV prevention education program is eligible for federal funding because mandates prohibit educating youth about the benefits of condoms and contraception." Despite this statement, contraceptive use has been shown to lower the rate of

pregnancies among teens. It seems important for young people to learn about contraceptives if they decide to engage in sexual behavior because that would help them avoid unintended pregnancies and STDs. Another concern is, how can you teach an abstinence-based sexual education program to teens who have already engaged in sexually active behavior and choose to keep engaging in that behavior? Hacker (2000) postulated that teens who choose abstinence want adults to support their decision to refrain from sexual activity, while sexually active teens prefer better access to contraception. The question that needs to be addressed is, how do teens get their information about contraception if the schools will not provide a comprehensive sexual education program?

"Some examples of erroneous or misleading information found in the curricula review include those in a program called Family Accountability Communication Teen Sexuality, known ironically as FACTS" (Nation's Health, 2004, p. 23). This program, which is federally funded, is used in numerous states and uses threats and scare tactics to get adolescents to abstain from sex. For example, when describing premarital sex, the FACTS handbook stated, "there are always risks associated with it, even dangerous life-threatening risks such as HIV/AIDS. Using contraceptives does not change this for teenagers" (Nation's Health, 2004, p. 23). Although these programs do have their flaws, they are also commended because they involve parents and stress that family communication is a crucial piece to success. "Some of the falsehoods being spread in abstinence-only programs are that five percent to ten percent of women who have legal abortions become sterile and that HIV can be transmitted via sweat and tears" (Nation's Health, 2004, p. 23).

Presently, the two main curriculums taught in the schools in the United States are abstinence-only-until-marriage and a comprehensive approach. Most schools teach and advocate

for abstinence-only-until-marriage, which is partially funded by the state. "Even though pregnancy rates are declining in the USA, it still has higher teen pregnancy rates than most Western Countries" (Mabray & Labauve, 2002, p. 42). Given that these rates are higher than most other countries, it could suggest that these curriculums are failing to reach a particular teen population.

Youth with disabilities also have a right to sexual education. Many people tend to forget that they have the right and opportunity to learn about human sexual behavior and health. However, it is important to make the sex education curriculum as important and beneficial to them as it is or would be for youth without disabilities. People with disabilities were often sterilized and the idea of marriage or sex was not promoted. Society has generally frowned upon those with disabilities engaging in sexual behavior or discussing their sexual preference. For example, John F. Kennedy's sister, who was cognitively delayed, is a horrific case in point. "In 1941, her father, Ambassador Joseph P. Kennedy, had her lobotomized to curtail her developing interest in sexuality. Tragically, the lobotomy failed and left her more severely disabled. Since then, she has lived her life in a Wisconsin institute" (Campos, 2002, p. 192). Overall, youth with disabilities are not provided with adequate sexual education and are often taught to repress their sexual feelings. According to Campos, there are several studies that confirm the limited amount of sex education for youth with disabilities. One study found that half of the youth with disabilities did not receive any sexual education. Ironically, those who did not receive any sex education did not have any knowledge regarding sex in the context of their disability. Another study found that nearly 80% of youth with disabilities had knowledge of sex, however, only 20% of those youth learned about sex from a school-based program. Those who learned from the school-based program found that the information they learned was inaccurate and irrelevant.

One investigation found that individualized education programs (IEP) rarely mentioned sex education as a long or short term goal in terms of the IEP (Campos, 2002). Consequently, some people still think that those with disabilities are not sexual beings and do not need sexual education because they will never have sex or they are incapable or uninterested in the information. If these youth are not granted the right and knowledge of sexual education, they have a very high possibility of being unsure as adults how to create and maintain relationships, especially when they become sexually active. They are also more vulnerable to abuse. One teen explained his experiences regarding dating, sexuality, and marriage. John, 16 years old, has cerebral palsy, a speech impairment, and a hearing disability. He uses crutches or an electric wheelchair for mobility. He explained his confusion and frustration below:

> I haven't even had a date yet. Sometimes I fantasize about marriage, but I haven't really thought about it much. Sex education at school last year gave me the general information. My parents have tried to talk to me about it, but we haven't had a real discussion yet. (Campos, 2002, p. 194)

This testimony confirms that youth with disabilities are interested and have a right to know what other students without disabilities are learning.

Funding

Funding in schools can sometimes be limited and inadequate. When a program is funded in the schools, it can be seen as a great investment. The federal government does not mandate sex education, although many school districts teach about sexuality. How do most school districts pay for sexual education program funding then? Two federal acts help clarify this answer: first, Title X of the Public Health Service Act (1970), and second, PL-104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (1996). Title X gets

approximately $250 million yearly in grants to help encourage states and schools to deliver an abstinence-only sexual education curriculum. The funds were offered to states whose programs promoted abstinence from premarital sex. "Each year from 1998-2002, $50 million was available to the states with the awards ranging from $78,526 to $4.9 million. The rewards require the states to match 75% of the funds with public or private monies" (Campos, 2002, p. 17). All (including the District of Columbia) states have applied for funds and as of 1999, all but two accepted federal funds to support a total of 698 abstinence-only programs. However, abstinence-only supporters declare that 3 million federal dollars have been wasted on family planning/sex education programs because the number of teenage pregnancies and abortions increased.

What if that funding is not helping the students? According to Nation's Health (2004, p. 23), "federally funded abstinence-only education is often misleading and inaccurate." This review looked at six popular curriculums for abstinence-only programs taught to youth nationwide. "Although the curriculums varied, the reviewers found that the majority of the programs were based on religious beliefs, rely on fear and shame, omit important information, include inaccurate information, and present stereotypes and biases" (Nation's Health, 2004, p. 23). The federal government has invested nearly $620 million for abstinence-only-until-marriage programs to be taught in the schools. And in December of 2005, nearly $104.5 million was owed for community-based abstinence education. With this much money to support these programs, there is little to no evidence that shows these programs have had a long term impact on adolescents and their sexual behavior.

"In 1996, the United States Congress established an abstinence education program which funded a provision to support abstinence-only-until-marriage education, which teaches abstinence as the only effective means of preventing teen pregnancy" (Feijoo, 1999, n.p.). "Since autumn 1996, Congress has allocated over $300 million to fund unproven abstinence-only-until-marriage programs, which exclude information about condom and contraception use in preventing teen pregnancy, HIV/AIDS, and education about STDs" (Mabray & Labauve, 2002, p. 33). Abstinence-only education is supported by the Title V program and addresses issues such as the prevention of teen-pregnancy, however, HIV and STDs are not discussed within the curriculum.

According to the state of Washington, in 2007, the Bush administration decided to cut off funding for abstinence-only programs because now the state requires schools to talk about medically accurate information regarding prevention of pregnancy and sexually transmitted diseases. The state was receiving $800,000 annually. The program had been used alongside a comprehensive approach as well. "Advocates for the comprehensive sex education law argued that the new curriculum would help reduce teen pregnancy and the spread of sexually transmitted diseases" (McGann, 2007, n.p.). However, the federal government will no longer provide the grant, which would have been approximately $200,000 this year.

According to S.D. Wire (2008), an author for the Los Angeles Times, Congress in 2008 agreed that abstinence should be the core of any sex education program for teens. The concern lies when individuals were talking about how much information students should receive, such as condom use and protection against sexually transmitted diseases. When states got the funding for sexual education programs, 49 out of 50 states adopted the program, California was the state that did not. Currently, 33 out of 50 states receive federal funding. "However, some states have

looked at the federal requirements as the federal government telling them they had to only do it one way, and they didn't like it" (Wire, 2008, p. 1). There is not a one size fits all approach when trying to determine the perfect program to be taught in schools. "But several witnesses emphasized that despite 11 years of federally funded abstinence programs, at a cost of more than $1.3 billion, teens are still having sex and becoming infected with sexually transmitted diseases" (Wire, 2008, p. 1). The people who support comprehensive programs encourage the idea that adolescents should receive the proper information to protect themselves. There are questions as to whether comprehensive programs receive federal funding or not.

Recently, House Republicans released their Fiscal Year 2012 Labor, Health and Human Services, and Education spending bill. One of the changes was a slash to funding the Teen Pregnancy Prevention Initiative, which is a program that invests in young people to help them learn the knowledge and skills to reduce the rates of teen pregnancies, increase youth access to evidence-based programs on prevention, increase relationships between teen pregnancy prevention programs and community resources, and educate others about the teen prevention programs that are available. The House Republicans cut the fund by $85 million to a total of only $20 million. The initiative was funded at $105 million in 2011. Also, according to Heitel-Yakush (2011), the bill also brings back dedicated discretionary funding for ineffective abstinence-only-until-marriage programs. According to Monica Rodriguez (cited in Heitel-Yakush, 2011, n.p.), "it is outrageous that conservative policy makers would decimate funding for proven, evidence-based teen pregnancy prevention programs while resurrecting funding for failed abstinence-only-until-marriage programs that the federal government's own study proved to be ineffective." It is also stated that the tax payers should be outraged because of this

hypocrisy to fund failed programs and gutting programs that have been proven to be effective in preventing unintended pregnancy, HIV and other STDs, and are cost effective.

As described above, many different components should be looked at when determining what programs would be beneficial for our teens. Evidence suggests that abstinence-only programs are outdated and a comprehensive approach is a more positive alternative. However, for a school to adopt a new program, it needs to go through different obstacles, especially funding. It is important for schools to do research and look at the support and evidence before switching to another program or modifying their current program. It seems that there is more support towards a comprehensive approach, but the main factor to keep in mind when teaching abstinence-only or a comprehensive program is that it should help delay the onset of sexual intercourse among adolescents and help them stay healthy.

Critical Analysis

After researching numerous articles, it could be suggested that abstinence-only programs is what are primarily taught in the schools. However, research from Mabray and Labauve (2002) suggested that abstinence-only programs may not be the smartest way to go. Comprehensive programs seem to be more favored by educators and researchers. The point in sexual education is to delay the onset of sexual intercourse, educate about sexually transmitted diseases, and teach different methods of contraception. But most importantly, it is about teaching adolescents to have the knowledge to make healthy and smart decisions about their sexual behavior. There are specific abstinence-only programs and comprehensive curriculums that are being taught in the schools. These programs, such as “Best Friends,” “Project Taking Charge,” “Choosing the Best,” “Worth the Wait,” and “Postponing Sexual Involvement,” are being taught in the schools today and have had some success with the youth, especially the comprehensive programs. For

example, “Project Taking Charge” is founded on ten values and really encourages parents to attend with their child to help make the communication of sex, STDS, pregnancy, and sexual abuse much easier. Realistically, not all parents can or want to be involved with their teens, much less talk with their teens about sexual behavior. This being the case, fortunately, there are other programs that can be offered to those who do not have the parental support or where parents do not need to be involved. The goal of such programs is to teach adolescents relevant information that they may have to cope with as teenagers growing up in today’s society. It is practical to assume that no matter what program is being taught to students, there will never be a decrease to 0% of adolescents engaging in sex, but rather, the chance to see statistics decrease based on what is being taught and to see a positive change in behaviors. This is noteworthy to mention, because a program needs to have sensible and realistic goals and take into account what is already occurring with teens in today’s society. Mabray and Labauve (2002) proposed a multidimensional approach that focuses on numerous components and tries to focus heavily on the at-risk population for pregnancies and STDs. This approach’s purpose is to add to the abstinence-only program and help adolescents who display at-risk behavior, such as being sexually active, being in a non-healthy relationship, or is diagnosed with a type of STD. Cultural and societal expectations versus reality are explored with this approach.

Overall, both programs help delay the onset of sexual activity, however comprehensive sexual education programs are the only ones that truly “protect adolescents from pregnancy and sexually transmitted illnesses at first intercourse and during later sexual activity” (APA, 2005, n.p.). “In contrast, scientifically sound studies of abstinence only programs show an unintended consequence of unprotected sex at first intercourse and during later sexual activity” (APA, 2005, n.p.). Comprehensive programs are not completely against abstinence. They do encourage

abstinence; however, they promote condom use and push for fewer sexual partners. The primary goal of both abstinence-only and comprehensive programs are one in the same, to help promote abstinence, there are just more components that help make up comprehensive programs. Overall, those who support either sexual education programs agree that these programs should primarily benefit our youth and society; "inform youth of human development, STDS, and reproduction; prepare youth to resist sex; teach youth to exhibit humane sexual behaviors; improve youth's attitudes toward sex and the opposite sex; and abate sexual abuse and sexual harassment" (APA, 2005, n.p.).

Another population that has a right and need to sexual education are those diagnosed with disabilities. Rarely is sexual education built into their special services or individualized education programs (IEP). If these youth are not given the opportunity to learn about sexual education and explore their own sexual needs, they tend to be put in vulnerable and confusing situations when it comes to relationships or dangerous environments. Sexual education is particularly beneficial to those diagnosed with a learning disability. Some of these youth who are diagnosed with a learning disability lack cognitive ability, emotional maturity, and judgment skills that are needed, especially in risky sexual situations. "Some of these youth have reasoning problems and find it difficult to interpret social cues such as body language, facial expression, and human emotions" (Campos, 2002, p. 196). Unfortunately, youth with learning disabilities are often seen as unpopular among their peers because they have "an inability to use language in social situations, an insensitivity to social cues, an inability to correctly perceive their own social status, and an inability to adapt to social situations" (Campos, 2002, p. 197). Another important aspect to keep in mind when discussing sexual education and youth with disabilities is their vulnerability to sexual abuse. Those with disabilities, especially those diagnosed with cognitive

delays, have a high rate of sexual abuse. "Youth with mental retardation are particularly vulnerable to sexual violence because they are often unaware that they are being abused. Without knowledge of sex and privacy issues, they are at risk for abuse and harassment" (Campos, 2002, p. 196). It is so important to stress their right to a sexually healthy lifestyle. According to Campos (2002, p. 197), "the Council for Exceptional children believe that youth with mental retardation can benefit from content or materials that are simple but appropriate for their intellectual functioning, concrete but reinforce the presented skills, and closely relate to life." One would hope by educating all youth, there is a better chance of them becoming more aware of STDs, unwanted pregnancies, sexual abuse/harassment, and making healthier decisions to benefit their overall quality of life.

Unfortunately, to run a program, schools need funding, and currently abstinence-only is being funded by the government. As described above, Washington's fund recently got cut because the abstinence-only program was not working and they wanted to take on a more comprehensive approach. An interesting point to keep in mind is that the requirement of sexual education varies from state to state. "Some states mandate sex education with provisions, some without, and some have no mandate" (Campos, 2002, p. 17). According to Campos (2002, p. 17), "the Alan Guttmacher Institute surveyed 825 superintendents about their district-wide sex education policies and found that 69 percent implement programs to teach youth about sexuality." Of those districts that teach sexual education, an abstinence-only curriculum, without discussing contraceptives is prevalent in 35% of those districts; an abstinence-plus program is taught in 51% of districts; and 14% teach a comprehensive model. Because of limited funding from the government, sex education programs tend to get put on the backburner; however, sex is very common among adolescents.

Recommendations

A possible recommendation could be for schools to try a different approach to their curriculum instead of teaching the same one. This could give evidence to better results and what may seem to work better for not only the educators, but also the teens. Another recommendation could be for more research towards comprehensive programs because there is a lot of research about abstinence-only programs. If schools were to try a different approach, this would make research more readily available and allow for evidence-based practice. Ideally, all districts, should be teaching sexual education as part of their health curriculum. Realistically, funding is short and not every district has the ability to afford the curriculum. It could be suggested that a committee or council is established in the district with educators and community members to help inform and provide adequate learning to adolescents about sex. This committee can promote in the schools and around the community. Therefore, it is not just provided in the education system, but also supported in the adolescents' community. By getting more members involved, it could help reduce the pressure for trying to find funding in the schools and could be a more collaborative effort. Essentially, youth need support through education and their community. This helps break down the line between educators and citizens of the particular district. Besides, getting community members involved on a committee allows for their input and sometimes those members see a different side of youth than what is being perceived in the schools. Overall, getting community members involved in the sexual education curriculum may help the curriculum's direction, and also with funding and having positive role models helping youth.

Conclusion

The ultimate challenge that educators and adults face is, how do we teach youth about sex? Through the decades, times have changed but sex has always remained a constant. However, the behaviors and risks associated with sex are changing and increasing. What was effective in the 1980's, may not be as effective now. Numerous programs are available to teach youth about STDs and unwanted pregnancies. These programs are also available to help youth realize unhealthy sexual relationships and skills to protect themselves. Youth who engage in sexual activity have the possibility of living a risky lifestyle. It is important to reach out to all youth, if one program does not work. As educators, it is our responsibility to learn and implement one that does.

Chapter III: Methodology

This research study was conducted to determine sexual education programs being taught to middle school students as well as to identify the effectiveness of the programs. This chapter will discuss the participants, survey, procedures, and methods of data analyses utilized in this study. This chapter will conclude with known methodological limitations.

Participants

The selection of subjects began in February 2012 with a formal request sent to a suburban area school district around the St. Cloud area in Minnesota. The participants in this study were from a 6-8th grade public middle school which enrolled 629 students. A total of 241 surveys were given to students in eighth grade. Parental and student permission was sought and obtained (Appendix A) before students were allowed to fill out the survey.

Survey

The survey used to collect data for this research was a self-developed tool used to obtain information from adolescents regarding their sexual education experiences. Although researchers in the past who examined sexual education programs used surveys to collect data, the surveys were not developmentally appropriate for an adolescent population. Furthermore, the surveys did not sufficiently examine the impact of the effectiveness of the sexual education programs being taught (see survey in Appendix B).

The survey developed for this study consisted of two sections: multiple choice and true/false questions. The multiple choice questions included information pertaining to age, gender, grade, sexual education factual information, and education experience. The true/false questions included information about sexually transmitted diseases, teen pregnancy, and contraceptives.

Procedures

To ensure that all students in the eighth grade were given the opportunity to participate in the study, consent forms were distributed during their health and physical education class. On the days of February 27 and 28, the researcher went from each health and physical education class to introduce the survey and hand out the consent forms to the students. All students were given consent forms and were informed that all forms, if the student and parent/guardian wished to participate, must be handed in to the school office by March 6, 2012.

When students returned the consent form to the office, they were given the survey to complete at their leisure and were instructed to hand it back into the school office. Most students completed the survey immediately in the office within 15 minutes. Each consent form and survey was coded with matching identification numbers to ensure that each student who completed the survey also had a completed consent form.

Data Analysis

Survey information was entered into the Statistical Program for Social Sciences (SPSS), Version 17.0. Data were analyzed using frequencies with descriptive statistics. There were no missing responses. Data were also based on the valid percent.

Limitations

There are a few methodological limitations to this study in regards to the sample techniques, data collection, and instrumentation. In regards to the sampling, data was collected from only one suburban school around the St. Cloud area, which limits generalizable information concluded from the study. In addition, the selection of students through the sampling procedure used, eliminated students in sixth and seventh grade to participate.

Regarding data collection, another limitation is that human error is likely to occur during data input and calculation. Although all appropriate measures were taken to decrease the likelihood of human error, such as cross-referencing and having one researcher collect all the data, small errors may have occurred. Additionally, since all participants in the study were minors, only those students whose parents completed and returned the consent form were allowed to participate, therefore, the data collected may be limited. Limitations were also present within the instrumentation of this study. Although the survey tool is valid, no information on the reliability of the tool is assessable.

Finally, as with any self-report instrument, such as the survey used in this study, the researcher assumes that the individual completing the survey to be completely honest and truthful. Respondents were instructed to give their best guess and answer all questions honestly; however, responses are prone to distortion by social desirability concerns.

Chapter IV: Results

The survey research was conducted to determine the effectiveness of sexual education programs being taught in the schools to middle school eighth grade students. Results from students' self-reported knowledge regarding sexually transmitted diseases, puberty, and different forms of contraceptives are described. Also explained are the results regarding students' comfort level when talking to their friends, parents, and teachers about sex. Additionally, information from students was provided about where they gained the majority of their knowledge regarding sex education. Finally, each the research questions stated in Chapter I will be discussed.

Results

Demographic data regarding the study's sample is outlined in Table 1. There were 241 consent forms given out to students in a St. Cloud area school. Eighty-one consent forms and surveys were returned. This constitutes a 33.6% return rate. Twenty-seven (33.3%) of participants were age thirteen and fifty-four (66.7%) were fourteen years of age. Of the 81 students, 59.3% were male and 40.7% were female.

The third survey question of this project pertained to what grade students learned about puberty and how the body changes. Most participants (81.5%) learned about this area in fifth grade. Meanwhile, 4.9% of participants learned about puberty in fourth grade and 3.7% of students were taught about puberty in sixth grade. Furthermore, 9.9% of participants were not sure when they learned about this topic. These results indicated that the majority of students surveyed were taught in fifth grade about puberty and how the body changes.

Students were then asked a series of four questions about the information they may have learned throughout their education in school. When asked if they had been taught about HIV and AIDS, 82.7% participants responded yes. Meanwhile, 9.9% responded no and 7.4% were not

sure if they had been taught about HIV and AIDS. The next question asked if they had been taught about STI or STDs in school. Seventy-nine percent responded yes. Again, 9.9% of participants responded no and 11.1% were unsure. The next question in this series inquired as to whether students had been taught about different forms of contraceptives. Most students (82.7%) reported yes and 11.1% reported no. The remaining 6.2% of participants were not sure if they had been taught about different forms of contraceptives. Lastly, an overall question was asked about the message that was being taught regarding the students' sexual education program. The majority of students (82.7%) responded that the message they were being taught was to abstain from sex until marriage, with added knowledge of different contraceptives, safety, and STDs. The message about abstaining from sex until marriage was being taught to 13.6% of respondents and just 3.7 participants reported that they were not sure what their sexual education program was teaching them. These results indicated that the majority of participants have learned about HIV and AIDS, STI/STDs, and different forms of contraceptives. The overall message that students have been taught is to abstain from sex until marriage, with knowledge of safety, STDs, and contraceptives.

Participants were asked where they have learned most of their sexual education from in order to identify the most influential source of information. Only 8.6% of students responded with their parents and 9.9% of participants responded with school. The media/TV was the biggest source of knowledge for students (53.1%), while friends came in second (28.4%).

The next set of questions broke down how comfortable students were talking to their parents, teachers, and friends about sex. The majority of participants (88.9%) responded with not at all comfortable when talking to their parents about sex, while 8.6% felt kind of comfortable and 2.5% felt very comfortable. The next question asked how comfortable students

felt talking with their teachers or school staff about sex and zero participants responded feeling very comfortable. Not at all comfortable was the most prevalent group with 97.5% of responses and 2.5% participants kind of felt comfortable. Participants were then asked how comfortable they felt talking about sex with their friends. Seventy-five (92.6%) participants selected very comfortable, three (3.7%) participants selected kind of comfortable, and three (3.7%) participants selected not at all comfortable. These results indicated that the majority of students felt very comfortable talking with their friends about sex and none of the participants felt very comfortable talking with their school staff about sex.

The next part of the survey asked a series of true/false questions in order to get an idea of what student's knowledge may be regarding a variety of areas that may have been taught in a sexual education program. In order to determine this, a frequency table using descriptive statistics was used.

The first true/false item of the survey stated, "The best way to not get HIV, AIDS, or STI is to not have sex." The collective results indicated that 79 participants (97.5%) responded "true" and two participants (2.5%) responded "false."

The second true/false item stated, "Some STDs put you at a higher risk of getting infected with HIV." The collective results indicated that the majority of students (70.4%) believe this statement to be "true," while 29.6% of participants responded "false."

The third true/false item regarding puberty stated, "Everyone goes through puberty, but not necessarily at the same time." Seventy-eight participants (96.3%) selected "true." Three respondents (3.7%) chose "false."

The fourth true/false item stated, “Teen pregnancy can be avoided 100% by abstaining from sex.” Only 1 participant (1.2%) responded false, while the majority of participants (98.8%) selected “true.”

The fifth true/false item regarding contraceptives stated, “Contraceptives can 100% protect you from STDs, HIV, and pregnancy.” The collective results indicated that 91.4% believe this to be “true” and 8.6% responded “false.”

The sixth and final true/false item stated, “Puberty is a time of contrast because you shift from being a child to becoming an adult.” The collective results indicated that 84% of participants selected “true,” while 16% of respondents chose “false.”

Research Questions

The first research question in chapter I presented pertained to what message was being taught in the schools. According to the data obtained from question seven on the survey, the majority of students are still learning that it may be best to abstain from sex until marriage. They are also being educated on different forms of contraceptives, safety in sex and relationships, and different STDs. The second research question of this project determined if youth were being taught about a variety of STDs. As stated above, questions four and five on the survey reported 82.7% of participants have learned about HIV and 79% have been taught about a variety of STI/STDs within their sexual education program. The third research question in this study identified if students were being taught about different forms of contraceptives. Based on the responses provided on question six, 82.7% of respondents have learned about different forms of contraceptives. Furthermore, 91.4% responded false when asked if contraceptives 100% protect from pregnancy, HIV, and STDs on question sixteen. The final question in this project determined if the participants had learned about puberty and at what age did they learn about it.

Based on the majority of responses, the topic of puberty was first introduced to the participants in school at approximately 5th grade, according to question three on the survey. Also, the majority of responders were able to identify the main concept regarding puberty on the final question of the survey.

Chapter V: Discussion, Conclusions, and Recommendations

This chapter will summarize the general findings of this research project, which surveyed eighth grade students about their sexual education experience. This chapter will also discuss significant findings from the research on the knowledge base regarding sexually transmitted diseases, contraceptives, and puberty and where the majority of this information was learned. Conclusions of the research as well as recommendations for future research, will be included.

Discussion

Results indicated that the participants were taught a comprehensive sexual education curriculum. Many researchers suggest that this type of curriculum appears to work best because of the numerous topics covered and our evolving society.

The majority of participants have been taught about STDs, different forms of contraceptives, and HIV/AIDS. Even though the majority of participants have learned about these topics, there were still approximately 10% of the respondents who had not. According to the Washington Independent (2011, n.p.), the U.S. median is 86% of youth who are taught about HIV/AIDS in school. In this study, 82.7% have been taught about HIV/AIDS. Even though the sample size in this study was limited, the findings are relatively similar to the U.S. median. All of the participants were in eighth grade, however, many of them have been taught differently. Sixty-six participants were first exposed to sexual education in fifth grade at school. It may seem that fifth grade is an early age to start exposing students to sexual education; however, over half of the participants are learning their sexual knowledge from TV/Media and about 28% are learning from their friends. With these statistics, it makes one wonder if fifth grade really is too late, is the information being learned from these other sources factual, and does school need to implement their curriculums earlier to reach out to those students who may have an advanced

knowledge? Since the TV/Media appears to be where most participants are acquiring their sexual education knowledge, it is refreshing to find that these participants are receiving the message about HIV/AIDS, different forms of contraceptives, safety, and abstaining from sex may be best. With this specific sample, 82.7% of students are gaining a comprehensive curriculum regarding sexual education. When combining the information learned from the TV/Media and friends, a comprehensive sexual education program seems to fit best since these students are learning far more than just abstaining from sex. The comprehensive sexual education programs allow for factual information to be presented to students and address all the areas that students may already have learned.

Of the participants who had been surveyed, 92.6% felt very comfortable talking with their friends about sex. If students are talking to their friends about sex, they are definitely learning about sex, which helps clarify the previous finding about where they learn their sexual education. In contrast, only 2.5% of students felt very comfortable talking to their parents about sex and no one felt very comfortable talking to their teachers.

A particularly interesting finding was that not all participants knew that contraceptives cannot 100% protect you from STDs, HIV, and pregnancy. About 7 participants thought they did 100% protect you, while 74 respondents knew they did not 100% protect. This statistic may be due to some participants not answering in a truthful manner or that some participants actually do believe that the purpose of contraceptives is to keep you 100% safe.

Conclusions

Because of funds, schools have created their own way to provide sexual education to their students. There has not been one proven way that absolutely works; however, researchers are in favor of a multi-dimensional, comprehensive approach. One way that is actively being

taught is a multi-dimensional, comprehensive curriculum. This curriculum focuses on healthy relationships and the overall sexual wellbeing of adolescents.

The TV/Media still seems to be the primary source of information regarding sexual education. Since this is where most adolescents are gaining their information from, it may be interesting to see how schools can find a correlation between the TV/Media and their curriculum to help create a factual, and realistic curriculum.

The majority of students learned in fifth grade about puberty and how the body changes. Their next exposure to a comprehensive program was in the beginning of their eighth grade year. Because students learn about sex through their friends and TV, eighth grade may be a late time in their schooling and it seems that a comprehensive approach could be more effective at an earlier age.

An overall knowledge of sex can help adolescents make safe and healthy choices. Adolescents seem to rely heavily on their friends as a support system when talking about sex. Even though adolescents don't feel very comfortable talking with their parents or school staff, there are still numerous ways in which parents, school districts, and communities can stay involved and continue to teach and support the sexual health and safety of adolescents. Having parents, school districts, and communities on board to help can provide consistency and continual knowledge for students. As stated in chapter III, a collaborative board of directors including community members and school district personnel may be a successful combination. This allows for adults who interact with the youth of the community who may not be in the schools to help teach the message about safe sex. These adults along with school personnel can work together to provide different programs that may become available to youth in addition to the sex education programs they may already be receiving in the schools. It may also provide

opportunities for more programs to be offered to youth to continue to teach them about risky sexual behavior and the consequences of their choices. These programs can be offered to a variety of ages and not have the limitation that the school district may have, which teaches them in certain grade levels for a certain time frame. Having community members along with school personnel work together to help support the youth with all that encompasses sexual education can provide more than a curriculum; these members may offer support groups, safe dating groups, informative classes about STDs and HIV, contraceptive options, body dilemmas, and anything else that will help give youth more exposure to sexual education and information about risky behavior.

Implications for Practice

The information gained from this study allows for further involvement with programs that are being offered within the schools. Furthermore, having the background research and knowledge regarding sexual education curriculums can be viewed as an asset to the teaching and curriculum team. This information will also be helpful when presenting possible curriculums or goals to those working with students with disabilities. Given the research, students with disabilities need to be taught sexual education. It may be beneficial to start addressing the students' educational needs regarding their body development and sex at IEP meetings and assist with helping make short or long term goals to help them learn more about sex education. Research can also continually be explored to find curriculums to help teach students with disabilities more about sex education. This may be appropriate to teach them when they are learning about life skills.

Implications for Further Research

Findings of the research conducted in a middle school setting with eighth grade students indicate that the majority of students have received a comprehensive sexual education curriculum. Further research on the different sexual education programs taught in schools needs to continually be explored. There are always federal funds and budget cuts that make teaching a solid, well-rounded curriculum difficult. Also, because the results of this study are limited due to a small sample of participants in the school system, a larger and more diverse sample size is needed for more generalizable results. Furthermore, since this study was based on results from a self-report instrument, further research which combines both formal (i.e., standardized instruments) and informal (i.e., interviews, observations) research tools is needed to fully gain the knowledge of the different programs that are being taught and what is working. Future research is also recommended to identify if all students are receiving the same curriculum or how schools are differentiating their curriculums to meet the needs of those who may be in special education.

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Appendix A: Consent to Participate in UW-Stout Approved Research

Title: *The Effectiveness of Sexual Education in the Schools*

Investigator: Becky Daschel, M.S. Ed.
651-387-7416, daschelr@my.uwstout.edu

Research Sponsor: Dr. Amy Gillett, Ph.D.
715-232-2680, gilletta@uwstout.edu

Dear Parent/Guardian:
Your child is being invited to complete a survey for the purpose of researching the effectiveness of sexual education programs in the school setting. Please review the following information about the research being conducted.

Description:
The survey includes questions pertaining to your child's knowledge regarding their sexual education experience.

Schools use a variety of different programs throughout their health education curriculum. Some of them may be less effective than others. The specific purpose of this study is to gain knowledge on the different sexual education curriculums that are being taught and which ones seems to be more effective for middle school students. There is conflicting research regarding these different curriculums. The information that your child offers on the survey will add to existing research on sexual education programs and will help inform parents, professionals, and other community members.

Risk and Benefits:
The results of the survey will be beneficial to the researcher and your child in the following ways. First, the survey will provide the researcher with new information regarding sexual education programs being taught in the schools. Secondly, the survey will provide your child with experience in reading and answering survey questions. Finally, the survey will benefit your child by providing them an opportunity to reflect on and evaluate their current sexual education program and what they have learned in the past. Risks of the survey are minimal; however, the survey asks your child about different terms used when speaking of sexual education, which may cause them to feel slightly nervous or uncomfortable. Students will be asked to evaluate what they know regarding puberty, sexually transmitted diseases, and different forms of contraceptives.

Special Population:
Since the survey must be completed by your child, the signature of your child, along with the parent/guardian is required. If you choose to allow your child to participate, please be sure that both you and your child sign the bottom of the consent form.

Time Commitment and Payment:
It will take approximately 5-10 minutes to complete the survey. Participation is voluntary and no form of payment will be given for the completion of the survey. In addition, there will be no form of consequence or punishment on behalf of the child or parent/guardian for choosing not to complete the survey.

Confidentiality:
The highest level of confidentiality will be maintained. Neither your child's name nor the parent/guardian's name will be included on the document. Thus, neither your child nor the parent/guardian will be identifiable in any part of the research results. The informed consent will be kept in a separate file removed from any of the other project documents.

Right to Withdraw:
Your child's participation in this study is entirely voluntary. Your child and/or the parent/guardian may choose not to participate without any adverse consequences. Should your child or the parent/guardian choose to participate and later wish to withdraw from the study, the child may discontinue participation at this time.

IRB Approval:
This study has been reviewed and approved by the University of Wisconsin – Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding the study, please contact the Investigator or Advisor. If you have questions, concerns, or reports regarding your rights as a research subject, please contact the IRB administrator.

Investigator: Becky Daschel, M.S. Ed.
651-387-7416, daschelr@my.uwstout.edu

Advisor: Dr. Amy Gillett, Ph.D.
715-232-2680, gilletta@uwstout.edu

IRB Administrator:
Sue Foxwell, Director, Research Services
152 Vocational Rehabilitation Building
University of Wisconsin-Stout
Menomonie, WI 54751
715-232-2477
foxwells@uwstout.edu

Statement of Consent:
By signing this consent form you agree to participate in the project entitled, *The Effectiveness of Sexual Education Programs in the Schools.*

_____

Signature of participant (child) Date

_____

Signature of parent/guardian Date

Appendix B: Survey

Your Sexual Education Experience

Directions: Please respond to the following questions by circling one of the multiple choice answers. Please answer all of the questions asked.

1. How old are you?
    A. 13 years old
    B. 14 years old
    C. 15 years old
    D. 16 years old

2. What is your gender?
    A. Male
    B. Female

3. In what grade did you learn about puberty and how the body changes?
    A. 4th Grade
    B. 5th Grade
    C. 6th Grade
    D. 7th Grade
    E. Not Sure

4. Have you ever been taught about AIDS or HIV infection in school?
    A. Yes
    B. No
    C. Not sure

5. Have you ever been taught about other sexually transmitted infections (STI or STD) in school?
    A. Yes
    B. No
    C. Not sure

6. Have you ever been taught about different forms of contraceptives in school?
    A. Yes
    B. No
    C. Not sure

7. What was the message that your sexual education program taught you?
    A. Abstain from sex until marriage
    B. Abstain from sex and knowledge of different contraceptives, safety, and STDs
    C. I just learned about contraceptives and AIDS/HIVS
    D. Not Sure

8. Where have you learned **most** of your sexual education from?
    A. Parents
    B. School
    C. Friends
    D. TV/Media

9. How comfortable are you talking about sex with your parents?
    A. Not at all comfortable
    B. Kind of comfortable
    C. Very comfortable

10. How comfortable are you asking questions about sex with your teachers or other school staff?
    A. Not at all comfortable
    B. Kind of comfortable
    C. Very comfortable

11. How comfortable are you talking about sex with your friends?
    A. Not at all comfortable
    B. Kind of comfortable
    C. Very comfortable

Directions: Please answer the following True/False questions:

12. One of the best ways to not get HIV, AIDS, or STI is to not have sex.
    A. True
    B. False

13. Some STDs put you at higher risk of getting infected with HIV.
    A. True
    B. False

14. Everyone goes through puberty but not necessarily at the same time.
    A. True
    B. False

15. Teen pregnancy can be avoided 100% by abstaining from sex.
    A. True
    B. False

16. Contraceptives can 100% protect you from STDs, HIV, and pregnancy.
    A. True
    B. False

17. Puberty is a time of contrast because you shift between feelings of being a child and becoming an adult.
    A. True
    B. False

Appendix C: Survey Response Tables

Q1: Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	13	27	33.3	33.3	33.3
	14	54	66.7	66.7	100.0
	Total	81	100.0	100.0	

Q2: Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	48	59.3	59.3	59.3
	Female	33	40.7	40.7	100.0
	Total	81	100.0	100.0	

Q3. Grade learned about puberty and body changing

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4th Grade	4	4.9	4.9	4.9
	5th Grade	66	81.5	81.5	86.4
	6th Grade	3	3.7	3.7	90.1
	Not Sure	8	9.9	9.9	100.0
	Total	81	100.0	100.0	

Q4. Taught about AIDS or HIV in school

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	67	82.7	82.7	82.7
	No	8	9.9	9.9	92.6
	Not Sure	6	7.4	7.4	100.0
	Total	81	100.0	100.0	

Q5. Taught about STI or STD in school

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	64	79.0	79.0	79.0
	No	8	9.9	9.9	88.9
	Not Sure	9	11.1	11.1	100.0
	Total	81	100.0	100.0	

Q6. Taught about forms of contraceptives

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	67	82.7	82.7	82.7
	No	9	11.1	11.1	93.8
	Not Sure	5	6.2	6.2	100.0
	Total	81	100.0	100.0	

Q7. Message Sex. Ed. Program taught you

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Abstain from sex until marriage	11	13.6	13.6	13.6
	Abstain from sex until knowledge of different contraceptives, safety, and STDs	67	82.7	82.7	96.3
	Not Sure	3	3.7	3.7	100.0
	Total	81	100.0	100.0	

Q8. Where have you learned most of your Sex. Ed. From

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Parents	7	8.6	8.6	8.6
	School	8	9.9	9.9	18.5
	Friends	23	28.4	28.4	46.9
	TV/Media	43	53.1	53.1	100.0
	Total	81	100.0	100.0	

Q9. Comfortable talking about sex with parents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all Comfortable	72	88.9	88.9	88.9
	Kind of Comfortable	7	8.6	8.6	97.5
	Very Comfortable	2	2.5	2.5	100.0
	Total	81	100.0	100.0	

Q10. Comfortable talking about sex with teachers or school staff

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all Comfortable	79	97.5	97.5	97.5
	Kind of Comfortable	2	2.5	2.5	100.0
	Total	81	100.0	100.0	

Q11. Comfortable talking about sex with friends

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all Comfortable	3	3.7	3.7	3.7
	Kind of Comfortable	3	3.7	3.7	7.4
	Very Comfortable	75	92.6	92.6	100.0
	Total	81	100.0	100.0	

Q12. Best way to not get HIV, AIDS, or STI is to not have sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	79	97.5	97.5	97.5
	False	2	2.5	2.5	100.0
	Total	81	100.0	100.0	

Q13. Some STDs put you at higher risk of getting infected with HIV

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	57	70.4	70.4	70.4
	False	24	29.6	29.6	100.0
	Total	81	100.0	100.0	

Q14. Everyone goes through puberty, but not necessarily at same time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	78	96.3	96.3	96.3
	False	3	3.7	3.7	100.0
	Total	81	100.0	100.0	

Q15. Teen pregnancy can be avoided 100% by abstaining from sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	80	98.8	98.8	98.8
	False	1	1.2	1.2	100.0
	Total	81	100.0	100.0	

Q.16 Contraceptives can 100% protect you from STDs, HIV, and pregnancy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	7	8.6	8.6	8.6
	False	74	91.4	91.4	100.0
	Total	81	100.0	100.0	

Q17. Puberty is a time of contrast because you shift from being a child to becoming an adult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	True	68	84.0	84.0	84.0
	False	13	16.0	16.0	100.0
	Total	81	100.0	100.0	