

**Resolution in Favor of Empirically Supported Sex Education
and HIV Prevention Programs for Adolescents**

Passed by the APA Council of Representatives on February 20, 2005

WHEREAS the proportion of newly identified HIV cases among persons under 25 has increased since 1994 (CDC, 2002b); and,

WHEREAS statistical models suggest that half or more of all HIV infections occur before age 25 (Rosenberg et al., 1994); and,

WHEREAS most of those diagnosed with AIDS at ages 21 to 24 were most likely infected during adolescence as a result of the latency between acquiring HIV and an AIDS diagnosis; and,

WHEREAS death from AIDS, as well as new cases of HIV, in adolescence disproportionately occurs among females and persons of color (CDC Survey, 2001; U.S. Department of Health and Human Services, 2001); and,

WHEREAS adolescents are at risk for HIV primarily through their sexual behavior (CDC, 2004a) and males who have sex with males continue to constitute the majority of adolescents living with and/or newly infected with HIV (CDC, 2001; 2002 &c); and,

WHEREAS approximately 64% of heterosexually acquired HIV infections reported in the United States during 1999-2002 occurred in females and the proportion of HIV-infected females was highest among persons aged 13-19 years (CDC, 2004b); and,

WHEREAS the following have been identified as risk factors for HIV: early age of sexual debut, more frequent intercourse, less consistent use of condoms, more than four sexual partners, the co-occurrence of a sexually transmitted illness (STI), and anal or vaginal intercourse with an infected partner (CDC, 2002b & c); and,

WHEREAS in many urban areas of the country a common age of first sexual intercourse among specific subgroups of adolescents is age 12 for males with the national average being age 16 (Aten, et al., 2002; Post & Bokin, 1995; Raine, Jenkins, Aarons, et al., 1999); and,

WHEREAS one in five young people have sex by age 15 (Albert et al, 2003); and,

WHEREAS several subgroups of adolescents are at an elevated risk for HIV infection, including adolescents of color, homeless adolescents, males who have sex with males (MSM), gay, bisexual and transgendered adolescents, injection drug using adolescents, victims of sexual abuse, mentally ill adolescents, and adolescents in the juvenile justice or foster care system (Futerman, Chabon, & Hoffman, 2000); and,

WHEREAS the use of condoms can substantially reduce the risk of HIV infection (CDC, 2003 p. 9; CDC, 1993; Crosby, DiClemente, Wingood, Lang, Harrington, 2003; Macaluso, et al, 1999); and,

WHEREAS most adolescents who are sexually active do not use condoms consistently (Keller et al., 1991); and,

WHEREAS young people report concerns about HIV/AIDS, but many do not perceive themselves to be personally at risk and lack accurate information about circumstances that put them at risk for HIV infection (Henry J. Kaiser Family Foundation, 2000); and,

WHEREAS there is limited evidence for the efficacy of abstinence-only and abstinence until marriage programs with only a few published scientific studies (Thomas, 2000; Denny, Young,

Rausch, Spear, 2002) that are quite limited as a result of a lack of randomization and homogeneity of samples, making behavioral change difficult to measure and the results not generalizable; and,

WHEREAS many published studies associated with abstinence-only education programs (Kirby, Korpi, Barth & Cagampang, 1997; Roosa & Christopher 1990; St. Pierre, Mark, Kaltreider, & Aikin, 1995; Christopher & Roosa, 1990) have failed to find a reduction in sexual behavior; and,

WHEREAS virginity pledges, abstinence-only programs, and abstinence until marriage programs have been shown to have the unintended consequence of increasing the probability that adolescents will have unprotected intercourse at the time of first intercourse (Bearman & Bruckner, 2001; Bearman & Bruckner, 2004); and,

WHEREAS virginity pledgers who contracted sexually transmitted diseases (STDs) were less likely to know they had an STD (Bearman & Bruckner, 2004); and,

WHEREAS abstinence-only and abstinence until marriage programs as a way to prevent HIV transmission have not been shown to be effective in long-term, randomized controlled studies, especially for sexually experienced adolescents (Bearman & Bruckner, 2001; Jemmott, Jemmott & Fong, 1998; Kirby, Korpi, Barth & Cagampang, 1997); and,

WHEREAS abstinence until marriage programs make no effort to address the unique needs of lesbian, gay, bisexual and transgendered (LGBT) adolescents and thereby discriminate against LGBT adolescents who are disproportionately affected by HIV and who are precluded by law from marrying; and,

WHEREAS abstinence until marriage programs imply that LGBT adolescents should remain unrealistically abstinent for life because they make no effort to address the unique needs of LGBT adolescents; and,

WHEREAS abstinence until marriage programs are inherently discriminatory and violate the 1975 APA antidiscrimination resolution on gay, lesbian, bisexual, transgendered and questioning individuals (see <http://www.apa.org/pi/lgbq/policy/statements.html#1>); and,

WHEREAS most comprehensive sexuality education programs include the message that abstinence or mutual monogamy with a partner known not to be HIV infected are the safest ways to prevent sexual transmission of HIV and thus support the goals of abstinence and delaying initiation of sexual behavior (CDC, 2003); and,

WHEREAS HIV prevention programs for youth that focus on delaying initiation of sexual behavior are valuable and justified on the basis of developmental theory; and,

WHEREAS comprehensive sexuality education programs that provide 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 STDs, and teach sexual communication skills are effective with sexually experienced adolescents (Mullen et al, 2002); and,

WHEREAS comprehensive sexuality education programs that discuss the appropriate use of condoms do not accelerate sexual debut (Blake, 2003; Guttmacher, et al., 1997; USPHS, Surgeon General 2001) and yet do decrease pregnancy rates (CDC, 2004c); and,

WHEREAS empirical research shows that comprehensive sexuality education programs decreases the likelihood of unprotected sexual intercourse at the time of first intercourse (Main, et al., 1994; Kirby, 2000; Kirby, 2001) and reduces sexual risk behaviors that contribute to HIV (CDC, 1999; O'Donnell, 2002); and,

WHEREAS targeted comprehensive sexuality education programs for adolescents have been shown to decrease high risk sexual behaviors among gay, lesbian and bisexual youth (Blake, et al., 2001; Kegeles, Hayes & Coates, 1996; Remafedi, 1994; Rotheram-Borus, Rosario, Reid & Koopman 1995; Rural Center for AIDS/STD Prevention, 2002; Wright, Gonzales, Werner, Laughner, & Wallace, 1998); and,

WHEREAS targeted comprehensive sexuality education programs for substance dependent adolescents have been shown to, not just decrease high risk sexual behaviors, but to increase the number of adolescents who abstained from sex (St. Lawrence, Crosby, Brasfield & O'Bannon, 2002); and,

WHEREAS targeted comprehensive sexuality education programs for high risk adolescents in family and community-based institutional settings allow for access to hard-to-reach adolescents and they have been demonstrated to be effective, particularly in increasing condom use and condom acquisition (Harper & Robinson, 1999; Jemmott & Jemmott, 2000; Lightfoot & Rotheram-Borus, 2000; Peterson & DiClemente, 2000); and,

WHEREAS comprehensive sexuality education programs are effective in reducing risky behaviors and HIV transmission (Rotheram-Borus et al., 1998) and increasing condom use among those having sex for the first time (Rosenfeld, Myer, Merson, 2001; Low-Beer & Stoneburger, 2001); and,

WHEREAS comprehensive sexuality education programs are effective in preventing high risk sexual behaviors for adolescents living with HIV (Rotheram-Borus, et al., 2001); and,

WHEREAS a considerable body of evidence shows that comprehensive sexuality education programs focusing on both abstinence and condom use for those who choose to have sex have resulted in reductions in HIV-risk behavior and delays in the onset of intercourse (Collins et al., 2002; Kirby, 2001; Pedlow & Carey, 2001); and,

WHEREAS current Federal policy and practice in support of abstinence-only programming is based on little scientific evidence (Thomas, 2000) and thus may result in negative consequences for adolescents such as increased pregnancy rates or STDs; and,

WHEREAS a majority of parents support comprehensive sex education programs for their children (Henry J. Kaiser Family Foundation, 2000); and

WHEREAS the Institute of Medicine (Ruiz, 2001) and numerous professional and health organizations (e.g., the American Academy of Pediatrics, the American College of Obstetricians & Gynecologists, the American Medical Association, the American Public Health Association, the National Education Association, the National Medical Association, the National School Boards Association, the Society for Adolescent Medicine, Planned Parenthood Federation of America, Advocates for Youth and Sexuality Information and Education Council of the United States) support comprehensive sexuality education programs and recommend the elimination of existing congressional, federal, state and local mandates for abstinence-only and abstinence until marriage programs that censor information about condoms and contraception for the prevention of pregnancy and STDs including HIV; and,

WHEREAS the Department of Health and Human Services Strategic Plan for Fiscal Years 2002-2008 has as its first goal to prevent the spread of disease and illness, focusing in part on providing education and other materials to reduce unsafe sexual behaviors *U.S. Department of Health and Human Services, Strategic Plan, FY 2003-2008, p. 2); and,

WHEREAS the Administration's 2005 budget proposes to double funding to \$270 million for abstinence only education programs; and,

WHEREAS Federal guidelines (Devaney, et al., 2002, p. 31, 34) recommend that programs to prevent HIV/STIs among youth be based on empirical evidence derived from methodologically sound studies characterized by:

- a) adequate sampling strategies to ensure minimum selection bias and maximum generalizability; and,
- b) valid and reliable measurement techniques; and,
- c) the use of appropriate comparison groups; and
- d) pre and post-intervention assessment that includes long-term follow-up to ensure maintenance of intervention effects.

THEREFORE, BE IT RESOLVED that the American Psychological Association (APA) strongly supports the foregoing Federal guidelines and further recommends:

that programs to prevent HIV/STIs among youth include clear definitions of the behaviors targeted for change, address a range of sexual behaviors, be available to all adolescents (including youth of color, gay and lesbian adolescents, adolescents exploring same-sex relationships, drug users, adolescents offenders, school dropouts, runaways, mentally ill, homeless, culturally diverse and migrant adolescents), and focus on maximizing a range of positive and lasting health outcomes; and,

that widespread implementation of particular programs occur only in those instances when the efficacy and effectiveness of the programs have been well-established through sound scientific methods; and,

that new programs, including abstinence-only and abstinence until marriage programs, be tested in comparison to programs with proven effectiveness; and,

and that public funding for the implementation of comprehensive sexuality education programs be given priority over public funding for the implementation of abstinence-only and abstinence until marriage programs until such programs are proven to be effective.

BE IT FURTHER RESOLVED that the American Psychological Association supports efforts to:

Educate policy makers about research documenting the limitations of abstinence-only and abstinence until marriage programs, including their failure to attend to the prevention needs of MSM adolescents who are disproportionately affected by HIV/AIDS; and,

Encourage and promote policy makers to base funding decisions and laws on the well-designed scientific research with outcome data measured in terms of pregnancy rates, STIs, and HIV, as well as the health needs of young people, particularly those youth that are at elevated risk for HIV; and,

Urge state governments, Congress, and the executive branch to eliminate censorship of HIV safer sex messages in federally-funded HIV prevention programs; and

Promote comprehensive sexuality education programs designed to prevent HIV; and,

Promote HIV prevention as part of all adolescent mental health and substance abuse treatment and prevention programs; and,

Promote and encourage funding for research and program evaluation initiatives that are directed at youth and families who are at the greatest risk for HIV such as:

- Adolescent males who have sex with males, which remains the highest risk category (CDC, 1995; CDC, 2002c);
- Youth of color and especially young women of color aged 12-19 (CDC, 2004b);
- Adolescents with an early age of onset of sexual activity (CDC, 2002b, c);
- Adolescents with more than four sexual partners (CDC, 2002b,c);
- Runaway and homeless adolescents who engage in "survival sex." (Stricof, et al., 1990; Shalwitz, et al., 1990; Sweeney, et al, 1995; GAO, 1989; Rotheram-Borus, 1991; Rotheram-Borus et al, 1992; Yates, et al., 1988);
- Youth with a history of forced or coerced sex or sexual abuse (Goodenow, Netherland, & Szalacha, 2002; Lyon, Richmond, D'Angelo, 1996; NIMH Multisite HIV Prevention Trial Group, 2001);
- Youth with mental health problems (Brown et al., 1997; Donenberg & Pao, 2004);
- Youth in the juvenile justice system (Teplin, Mericle, McClelland, & Abram 2003);
- Transgendered adolescents (Garofalo et al., 2004);
- Ethnic minority adolescents (CDC, 2002c);
- HIV positive youth (Frederick, et al., 2000; Futterman, et al., 1990; Hein, 1989; Rotheram-Borus, et al., 1997); and

Promote and encourage programs that serve the needs of those whose sexual experiences, by law, occur exclusively outside of the context of traditional marriage, including men who have sex with men, gay, lesbian, bisexual and transgendered youth; and,

Promote training of psychologists in treating youth at risk and to document the need to add this training to all psychology training programs; and,

Promote and facilitate psychologists' acquisition of competencies associated with HIV prevention for youth, including mastery of the literature on HIV prevention and mastery of scientific evaluation of comprehensive sexuality education programs; and,

Encourage psychologists to be especially sensitive to the social and cultural biases which may result in some groups and individuals being underserved by abstinence-only and abstinence until marriage programs, as well as those receiving comprehensive sex education; and,

Work cooperatively with caregivers, families, medical providers, community based organizations, schools and multidisciplinary teams to improve the effectiveness of all programs designed to prevent HIV in youth; and,

Advocate for more rigorous evaluation of abstinence-only programs; and,

Advocate for increased funding for the widespread implementation of family, community and school based HIV prevention programs with proven effectiveness as demonstrated by rigorous evidence-based research.

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