Health Education as Social Advocacy:
An Evaluation of the Proposed Montgomery County Public Schools Health Education Curriculum

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INTRODUCTION

Health education has become a battleground in many locations due to the inclusion of sexuality education within the overall mission of health education. Sexuality education in any context is controversial. Issues of parental control, educator responsibility, morality, and health consequences for students all converge to make consensus difficult.

Numerous school districts have included various types of sexuality education in their health curricula. In recent years, advocates for students who experience same sex attraction have had significant impact in the schools. Many who are generally considered gay activists believe schools should discuss sexual variations. Some groups, such as those involved in the Gay Lesbian Straight Educators Network believe such teaching should begin in kindergarten and proceed through graduation.

How should health education be approached in relation to the problems of disease and pregnancy prevention? How should sexual variations be discussed in the middle school and high school classrooms, if at all? These questions demand serious attention from parents and educators.

This updated white paper is a response to the effort of the Montgomery County Public Schools to address disease, pregnancy and confusion concerning personal sexuality via health education among middle school and high school aged students. We have updated this paper in response to changes made to the curriculum by the MCPS in April, 2005.

The history of the effort to craft an effective health education curriculum has been detailed elsewhere. (http://www.mcps.k12.md.us/boe/meetings/agenda/2004-05/2004-1109/CACFLHD%202003-04%20STAFF%20.pdf).

Our purpose in reviewing the curriculum and updating our prior review is essentially to evaluate the facts presented in the curriculum. Is the material presented factual? Are some claims made that are essentially opinions that are presented as fact? Are some claims more dogmatic than they should be? Is the proposed condom demonstration video factually sound? We hope to present an evaluation of these issues based upon our knowledge of the social science research and sound educational practice.

Executive Summary:

In November of 2004, the Montgomery County Public Schools Board of Education (MCPS BOE) presented to the public their 2003-2004 Annual Report of the Citizens' Advisory Committee on Family Life and Human Development (CAC). This document was constructed to guide educators as they sought to inform their students about sexual behavior in the 8th and 10th grades. More specifically, the goal of the CAC was to help educators in two main ways: 1) to provide clear information about ways to avoid sexually transmitted diseases through the use of a video demonstration of condoms and 2) insert in the curriculum a tolerance education program about same gender attraction in order to decrease incidents of bullying and harassment of gay and lesbian identified students and to improve their self-esteem.

The curricula were again modified in April, 2005 and we wish to update our critique to reflect those revisions. We also include in this revision a thorough evaluation of the proposed condom demonstration video, Protect Yourself.

Given these important changes in the longstanding sexual education policies of the school district we sought to evaluate the MCPS report as a service to the school and the community. More broadly, we hope another point of view will help all concerned design an accurate curriculum that is useful to educators and will enable children to make informed choices.

Our Objectives:

- To examine the underlying assumptions of the educational material
- To examine the research cited to support the assumptions of the educational material
- To evaluate the assumptions and research for balance and accuracy
- To advise parents and the BOE as to changes in the curriculum which would be necessary to increase it's scientific accuracy and therefore it educational utility
- To provide additional resources for teachers to consult when preparing their sexual education instruction.

What We Found:

- The curriculum on contraception unnecessarily presents some material that may serve to promote sexual activity. Since adolescent sexual behavior is correlated with numerous negative outcomes, providing material that encourages sexual behavior seems counterproductive.

- The curriculum on same gender attraction is based on a theoretical orientation, called essentialism, which does not represent a singular consensus of opinion in the social sciences and research community concerning sexual orientation.

- Some very controversial issues and matters of debate within the psychological and medical communities were presented as settled facts.

- The essentialist assumptions in this curriculum undermine an important basic human trait: free will and choice. This is a critical educational value to the educators, administrators and parents.

- The curriculum does not adequately inform educators about how to prepare children who may experience same gender attraction for the health risks they may encounter should they identify as gay, lesbian or bisexual.

- The curriculum wrongly assumes that harassment of gays and lesbians will be ameliorated through this educational process. Although a worthy and necessary objective, to date there are no data to support such an assertion. On the contrary, there is evidence to suggest that the distress of gay and lesbian identified students may continue despite such efforts.

- The curriculum does not explore in depth the educational, financial and mental health benefits associated with sexual abstinence for teenagers.

- The curriculum appears to view with suspicion and/or neglect the role of traditional religious beliefs in assisting some adolescents to make healthy decisions. Further, some of the teacher resources favor some religious groups over others.

- The curriculum uses source documents provided by advocacy organizations. These advocacy organizations have a political agenda which undermines the educator's ability to present sound information to their students. Furthermore, curriculum resources completely omit scientific information, published in peer reviewed journals, which differ from the positions of these political advocacy organizations.

- The revisions made by MCPS staff are improvements. However, many of the issues raised above are still unaddressed.

- The condom demonstration video, Protect Yourself, contains significant factual errors. It should be discarded.

The curriculum could be more aptly titled: Presenting a Value Free, Essentialist Perspective on Human Sexuality. The key word here is perspective. If this material were presented as part of a debate class, or even as an editorial in the school newspaper it

would be understood that it was just one point of view. Restricting student's information to a biased point of view interferes with their full knowledge of what options are available to them in setting their life goals and managing their personal behavior to reach those goals. This seems completely contrary to the mission of the Montgomery County Public Schools. While the 2005 revisions are positive steps, we believe much more improvement can be achieved.

SECTION ONE - Foundational Observations

Even with the April, 2005 revisions, there are two basic elements of the curriculum:

1) New material on contraception, including a video that presents a demonstration of the proper method of condom application.
2) New material concerning sexual variations, specifically homosexuality and bisexuality.

In addition, the school district is considering a modification of guidelines to allow 9th grade students to participate in an educational experience designed for 10th graders. This change, at the outset of curriculum creation seems to undermine the attempt by educators to create a credible sexual education curriculum based upon the developmental needs of children.

Understanding the Adolescent Mind

No discussion of sex education should begin without understanding the developmental situation of adolescents. Consider the following: the adolescent mind is geared toward risk, rather than risk avoidance. This is due to a "profound remodeling" that occurs in the prefrontal cortex of the brain:

> "Almost half of the neural connections in the prefrontal cortex-the daily command center of the brain-are wiped out and decision-making shifts toward the brain regions that are governed by emotional reactivity. These massive changes…predispose adolescents to take more risks—and make them more vulnerable...Along with the brain's shift from its logic center, the level of dopamine in the amygdala, the brain's primitive emotional reactivity center, decreases."[1]

All of this suggests that adolescents take risks to achieve increasing levels of pleasure, as part of normal development. With adequate guidance and structure, these risks help adolescents understand and develop their skills through successes and begin to identify their deficits through failure. This "developing brain" makes adolescents quite vulnerable to impulsivity and influence from peers and media.

As adults, educators and parents, we bear a responsibility in guiding these changing children. Regardless of one's religious or moral convictions, there is a sound argument to be made for delaying sexual activity of all kinds until the brain has matured. Maintaining a completely neutral value system with adolescents tips the scale toward less comprehensive adult supervision, and therefore, more risky behavior that could have permanent consequences. They need to be encouraged to slow down and be cautious with behaviors that often have lasting consequences: namely sexual behavior. On the basis of these concerns, we suspect the school may be sending mixed messages to students via the use of the condom demonstration and the emphasis in the curriculum of avoiding "high risk" sexual behavior rather than sexual activity altogether.[2]

Considering the Impact of Sex Education

People in the United States report their first sexual experience as occurring at age 16.9 years on average. By contrast, Taiwan, reports their average age for similar behavior as 18.3 years.

It is important to note that the United States begins sex education 1.3 years earlier than children in Taiwan. In fact, there is a world-wide linear relationship between age sex education begins and sexual debut.[3] *In other words, the earlier a country initiates sexual education, the earlier adolescents begin to have sex*. An argument can be made that contraceptive based sex education may be unwittingly contributing to adolescents initiating sexual behavior. If such is the case, and the cross-cultural data suggests that it is, we should be very careful about the information that is dispensed during educational experiences.

Recent research indicates that adolescents seek information about sexual behaviors about one year prior to seeking information concerning sexually transmitted infections (STIs) and contraception.[4] The information presented to the 10th graders concerning condom demonstration will most likely be assimilated by students as assisting them in seeking sexual experiences. Given that students seek the "how to" information early, it seems reasonable to delay this information until they know more about the "when to."

We believe that the focus of sexual education must become oriented to primary prevention of risk based behaviors. In a 2004 review in the American Journal of Obstetrics and Gynecology, Drs. Genuis and Genuis made these observations after a thorough review of the literature regarding STIs and condom usage:

> The serious implications of the sexually transmitted disease (STD) pandemic that currently challenges educators, medical practitioners and governments suggest that prevention strategies, which primarily focus on barrier protection and the management of infection, must be reevaluated and that initiatives focusing on primary prevention of behaviors predisposing individuals to STD risk must be adopted…Human immunodeficiency virus/acquired immunodeficiency syndrome, human papillomavirus, genital herpes, and Chlamydia…illustrate the pervasive presence of STDs and their serious consequences for individuals and national infrastructures. Although risk reduction and treatment of existing infection is critical, the promotion of optimal life-long health can be achieved most effectively through delayed sexual debut, partner reduction, and the avoidance of risky sexual behaviors (from the abstract).[5]

We agree with this assessment but alas the revisions to the MCPS health curriculum take students in the opposite direction. It seems important to remember that a health curriculum purports to enhance health education. We urge the MCPS BOE to develop an approach that would seek the primary prevention goals outlined above: "delay of sexual debut, partner reduction and the avoidance of risky sexual behaviors."

Clarifying Educational Goals

Another consideration is the purpose of health education. Is the role of health education to communicate research based information or to advocate for social change? Many people look to health class to create responsible health conscious students. If the school wants this health curriculum to reduce bullying and teen pregnancy, then, as configured, it is unlikely to be successful. If research demonstrates anything, it conveys the idea that a single dose of information, whether it concerns abstinence or contraception, has little long term effects on adolescent behavior.[6] If behavior change is the desired outcome, then a much more comprehensive approach than is envisioned by this curriculum is needed.

Teaching on Sexual Variation

In 2002, the MCPS BOE directed the CAC and staff to make recommendations concerning how and what to teach about sexual variations. In his report to the BOE, Superintendent, Dr. Jerry Weast stated:

"In making this recommendation, the Committee recognized "the concept of sexual orientation as an essential human quality; [stated its belief] that individuals have the right to accept, acknowledge, and live in accordance with their sexual orientation, be they heterosexual, bisexual, gay, or lesbian;" (p3).

This is a statement of belief or philosophy, not fact. With this statement, the CAC, staff and BOE are taking sides in the scientific debate concerning sexual orientation. By declaring sexual orientation "an essential human quality," the committee has gone far beyond offering facts. The CAC, staff and BOE are inserting their beliefs about sexual orientation without acknowledging any other beliefs. Instead the "essential human quality" view is presented as established scientific fact.

Many lay people believe that sexual orientation is a concept well understood by science. However, this is not the case. The term itself is relatively new having replaced the term sexual preference in common usage the late 1970s. Contrary to the committee's assertion that sexual orientation is "an essential human quality," there is currently no means of objectively determining one's sexual orientation. There is no test, no procedure, experimental or otherwise, that can determine one's sexual orientation. The only means of understanding sexual orientation is through self-declaration.

This is an important point because this belief that people are inherently members of one sexual orientation or another informs the entire thrust of this curriculum. Nearly all of the factual errors we discovered can be traced back to this assumption on the part of the committee. No materials are available for teacher or student reading that contradict or provide an alternative to this "essential human quality" perspective.

Many people do not realize that there are multiple perspectives on sexuality taken by members of the research community. Belief in sexual orientation as a fixed trait is just

one of those views and by no means the dominant view in all of the social sciences. To present this view as fact to students is misleading.

In order to give the reader a fuller context for our remarks, we present a series of quotes from peer reviewed professional articles and books concerning sexual orientation.

Definition and Assessment of Sexual Orientation

Sexual orientation researchers Gonsiorek, Sell and Weinrich (1995) note that the most common means of assessing sexual orientation is via self-report. However, they also note that "there are significant limitations to this method." (Gonsiorek et al., 1995, p. 44) The most obvious problem is the subjective nature of self-assessment. Being gay, lesbian, or bisexual means different things to different people. Some define their sexual orientation by their behavior or attractions or fantasies or some combination of each dimension. After summarizing the difficulties in defining sexual orientation, Gonsiorek et al. (1995) state, "Given such significant measurement problems, one could conclude there is serious doubt whether sexual orientation is a valid concept at all." (p. 46) Concerning the potential for assessing change of orientation, Gonsiorek et al. (1995) note, "Perhaps the most dramatic limitation of current conceptualizations is change over time. There is essentially no research on the longitudinal stability of sexual orientation over the adult life span." (p. 46) According to these researchers, defining sexual orientation is a work in progress.[7]

Students should be made aware of these difficulties in definition and conceptualization. We suggest that students be made aware of the background of efforts to describe sexual variations which will give context for some of the issues that arise today concerning sexual orientation.

The following quotes are taken from E.M. Broido's article concerning sexual identity in the *Handbook of Counseling and Psychotherapy with Lesbian, Gay and Bisexual Clients*, published by the American Psychological Association. We include these quotes to give the reader an understanding of the issues related to the foundations of the proposed curricular changes. Lest the reader assume we are artificially creating a controversy where there is none, we want to make clear that the scientific and social science communities are not in consensus surrounding the foundational position of the proposed health education curriculum.

Essentialism Described

Fundamentally, essentialists believe that homosexuality and same-gender desire are the same thing and that homosexuality has existed, with fundamentally the same meaning, across many different cultures and historical eras, regardless of whether people defined themselves as homosexual. Stein (1990c) said the following in his review of the essentialism—social constructionism debate:

> *Essentialists think that the categories of sexual orientation (e.g., heterosexual, homosexual and bisexual) are appropriate categories to apply to individuals.*

> *According to essentialists, it is legitimate to inquire into the origin of heterosexuality or homosexuality, to ask whether some historical figure was a heterosexual or homosexual, etc. This follows from the essentialist tenet that there are objective, intrinsic, culture-independent facts about what a person's sexual orientation is. (pp.4-5)*[8]

This is the viewpoint that permeates the MCPS health education proposal. It is important to note that this is one perspective on the subject and not established scientific fact. What is troubling for us is not that a viewpoint is presented, but that it is a) presented as fact and b) not balanced with other viewpoints.

We are deeply concerned because the essentialist perspective of the proposed changes is an unacknowledged bias which significantly colors the presentation of material on same gender attraction. In so doing the curriculum strays significantly from an educational experience to an exercise in social advocacy.

Constructionism Described

Social constructionists reject the idea that there exists a fundamental, consistent meaning to or organization of sexuality across cultures and historical eras; they believe, therefore, that labels such as heterosexual, bisexual, and homosexual also have no consistent meaning across cultures and historical eras (Kitzinger, 1995), nor are they "the only or inevitable ways of organizing sexuality" (Clausen, 1997, p. 146).[9]

We can find nothing in the MCPS curriculum that would indicate this perspective is presented to students. As far as we can determine, any materials consistent with this view were rejected by the CAC.

Sexual Orientation: Current Perspectives

There is no singular "current perspective" on the notion of lesbian, bisexual, or gay identity. Those exploring biological and environmental determinants of sexual orientation largely do not interact with those exploring the social forces shaping the ways in which people construct their identities (but see De Cecco & Elia, 1993; Stein, 1990b). ***Although the social constructionist perspective seems to be the dominant viewpoint of those working within the humanities and social sciences****, representatives of these disciplines frequently critique the absurdities following from a strict constructionist perspective (e.g., if everything is a social construct, what, if any, basis is there for shared realities or questions?; Stein, 1990a).*[10]

Note that this APA publication documents that the definitions of sexual variations are in flux. There are competing perspectives at this time and the dominant perspective in the social sciences actually leans toward the social constructionist camp. Why would students not be informed about this position as it relates to sexuality? According to this gay affirming author, most people within the social sciences favor this view but some in

the hard sciences favor the essentialist view. The important point is that science has not established either view as the "accepted" position. Why does the MCPS?

Sexual Orientation: Essential Quality?

Many people report that their sexual orientation is a stable part of themselves and central to their identity. Others find their sexual orientation to be a more fluid identity. Some find it central to their sense of themselves, and others do not (Brown, 1995; Golden, 1987; Moses, 1978; Ponse, 1978; Rhoads, 1995). Counselors and therapists must be careful not to impose their own definitions of straight, lesbian, bisexual, or gay or to presume that sexual orientation is always central to identity, because their understanding of those terms and processes may differ from those of clients. Moreover, the use of only one of these terms may preclude clients' comfort in discussing the potentially fluid nature of sexual orientation.[11]

There are students who may feel that their sexuality is fixed but clearly there are students who do not. There are likely to be students who have decided not to pursue a gay or lesbian identity despite experiencing same sex feelings. When the MCPS presents only the essentialist position, it obscures other legitimate points of view, constricts the educational experience and undermines our children's ability to make informed choices

The curriculum presents a view that sexual orientation cannot change. However, even those experts writing in a gay affirming volume published by the APA are aware that sexual orientation can be flexible. Why would the BOE wish to withhold this information from students?

Change is Possible but Not Accepted by Essentialists

Because current Western society assumes sexual orientation to be a fixed and stable characteristic, changes in the gender of a person's object choice may be highly disconcerting to clients. Both heterosexual and gay and lesbian communities have placed a great deal of importance on the idea of sexual orientation being a fixed characteristic and sanction those who state that their experiences differ.[12]

This section addresses the assumptions that guide this curriculum. We know from working with people who are ex-gay that such sanctioning takes place. In fact, we wonder if the development of this curriculum is actually part of that sanctioning. The curriculum has no materials that speak to the research concerning constructionism, sexual orientation change, sexual identity dysphoria, etc.

Essentialist Argument is Used for Political Purposes

The lesbian, bisexual, and gay communities have found ways to use essentialist perspectives as effective tools in the struggle to acquire equal rights...To adopt a strictly constructionist perspective often is not helpful when working with the day-to-day realities of the lives of lesbian, bisexual, and gay people. More important, instead, is to validate

the experience of those who find sexual orientation, of any type, to be a central part of their identity, as well as to validate those for whom it is less immediate to their sense of themselves, and to be open to change in the meanings ascribed to these identities… (Noted constructionist writer) Kitzinger (1995) noted that even she can advocate an essentialist position when politically necessary.[13]

The candor of these writers is refreshing. The basic point here is that the essentialist viewpoint is politically expedient for those pursuing political change. Should the schools be used in this manner? We do not believe the BOE has been made fully aware of this issue. No responsible BOE would use a health education curriculum to advance political objectives at the expense of educational objectives. We hope and believe that the MCPS BOE will reevaluate the philosophical foundations of this curriculum before field testing and implementation.

Homosexuality a Mental Disorder?

From Dr. Weast's memorandum:

"Moreover, groups like the American Psychiatric Association, the American Psychological Association, the American Academy of Pediatrics, and every other mainstream medical and mental health organization in the United States have concluded that homosexuality is not a disease or mental disorder." (p.3).

This is correct. However, this point is irrelevant to the moral concerns of parents and is irrelevant to the essentialist foundation of the curriculum described above. Most developmentalist/constructionist thinkers do not consider homosexuality per se a mental disorder. While homosexuals are more at risk for a variety of health and mental health problems, this fact in itself does not make having same gender attraction a disorder.[14]

We do wonder why the risk factors attendant to a gay identity were not more obvious in the health education curriculum. This omission seems particularly troubling since the curriculum is supposed to be designed to help protect children during a vulnerable time. For example, recent research suggests that those at highest risk for HIV infection, young men with many sex partners, appear to be the least likely to have changed their sexual behaviors since the onset of the AIDS epidemic.[15] Despite being just 2-3% of the population, gay and bisexual men accounted for 44% of new HIV cases reported between 2000-2003.[16]

Is Health Education a Violence Prevention Tool?

From Dr. Weast's memorandum:

"The existing curriculum wisely taught about the importance of relationships and the development of families in ways that convey values of caring and responsibility. But the exclusion from that discussion of the fact that not all people are heterosexual, and that non-heterosexuals can have healthy and happy lives, was destructive to the mental health

of students who were not heterosexual. Indeed, that deafening silence may have fostered -- and certainly did not combat -- to use the words of the Staff Response, "the emotional distress and physical violence displayed toward them by some students and adults in the general population." (p.4).

This segment describes a problem and assumes the changes in the curriculum will solve it. Where is the support for the notion that physical violence was directed at gay identified students because of gaps in the health curriculum? Where is the evidence that if such problems exist that they will be remedied by these changes?

According to the Gay, Lesbian and Straight Education Network there is no evidence that such changes will lead to safer environments for students. By GLSEN's own admission, there is no research that any of the proposed curricular changes would curb harassment in the schools. According to Joseph G. Kosciw, PhD, a Research Analyst with GLSEN: "I am not aware of any peer-reviewed outcome research on training that includes sexual orientation. One of our research goals is to do some effectiveness research on our training curricula. But it hasn't happened yet."[17] When even advocacy groups acknowledge that there is no evidence of the effectiveness of changes in curriculum in preventing violence; why use teacher's and children's time in an unproven, perhaps ineffective intervention?

Finally, although the BOE goal of reducing the distress and victimization experienced by some gay identified students is admirable and necessary, there is growing evidence that some of this suffering may be independent of social stigma. Recent research from European countries which have taken a very pro-gay stance in the public policies (allow gay partnerships, have hate-crimes legislation, teach tolerance in public schools) indicates that these interventions have not improved the overall mental health of those with same gender attractions.[18]It is further important to note that in this comprehensive comparison of gay and straight men, they both reported similar levels of harassment and violence in school growing up.

Since educational dollars are scarce, it is important to spend them wisely. Children with same sex attraction and personal distress should not be educated that their symptoms are solely due to social stigma and prejudice. That stance could lead them toward a position of helplessness and away from a full exploration of their options to alleviate their stress. At the very least, they should be referred for a psychological evaluation to explore treatment options for their anxiety, depressive or substance abuse problems.

Teacher Resources Present Only One View

From Dr. Weast's memorandum:

"In addition, Teacher Resource materials were proposed; those materials were from reputable, mainstream organizations like the American Psychiatric Association, the American Psychological Association, the American Academy of Pediatrics, the National

Association of School Psychologists, the National Mental Health Association, and Advocates for Youth." (p.5)

The teacher resources are all consistent with an essentialist position and as such fail to give a complete picture of the field of study. Additional resources are suggested in the Appendix of this paper.

Including the Advocates for Youth in this list is an indicator of the bias of the curriculum. AFY is an advocacy group and not a professional body. They advocate for liberalized sexual education policy in the US and abroad. AFY promotes a video called "Teens and Sex in Europe." The video explains that Europeans are much freer about sex among teens and that such behavior is seen as normal there. The film is quite sympathetic to this ideology and suggests that perhaps the United States should follow suit. An example will be useful. In the video, a commercial from European television is replayed. A pharmacist sells condoms to a teen boy he obviously does not know. Then the scene shifts, and this same boy enters the pharmacist's living room with the pharmacist's daughter. The youngsters then announce their intentions to attend a movie. The young man and the father's eyes meet. The father's reaction was, "Fine, make sure you wrap up well."

In August of 2003, AFY teamed up with GLSEN to sponsor a "Bi-Youth Day" prior to the North American Conference on Bisexuality in San Diego. The main conference brochure touted workshops on "Teaching Bisexuality" and "Bisexuality 101." Many of the resources approved for teachers come from this group. In contrast, no abstinence based advocacy organizations are represented in this curriculum. Few abstinence based resources are made available for teachers.

Dr. Weast's memorandum goes on to outline additional specific changes proposed for the teaching of sexual variations. We consider these issues in detail in the following section.

SECTION TWO – Grade 8 Curriculum Evaluation

In this section we evaluate the factual nature of the changes proposed by the CAC. We only evaluate the relevant sections that were changed. Preexisting sections are omitted. We begin with the Grade 8 Health Education Curriculum – Revised.[19]

Under the section on Family Life and Human Sexuality (p. 9) for Grade 8, two new objectives are proposed.

By the end of the designated grade level (8th), the student should be able to:

- *Define terms related to human sexuality*
- *Define stereotyping and discuss generalizations regarding sexual identity. Students are also supposed to examine factors that influence stereotyping regarding sexual identity*

First, we present the original objective and accompanying content. Then we present the changes made in the April, 2005 revision. Finally, we give commentary concerning the proposed additions/changes. Original changes are in italics. Revised content is underlined.

OBJECTIVE: I. *Define Terms Related to Human Sexuality*

A. *What is Human Sexuality? This term refers to emotional closeness, sexual health and reproduction, and sexual identity. As we study human sexuality we will discuss how you develop your individual sexual identity. (Source: Life Planning Education, Advocates for Youth, Washington, D.C page 123)*

I. **Define Terms Related to Human Sexuality** (Please Note: the sources for the definitions are listed below for teacher use only. The definitions are to be presented to students as stated below – no additional information, interpretation or examples are to be provided by the teacher.)

A. What is Human Sexuality? This term refers to emotional closeness, sexual health and reproduction, and sexual identity. (Source: Life Planning Education, Advocates for Youth, Washington, D.C. page 123) (p.9).

We had expressed concern about the original addition of the objective "to discuss how you develop your individual sexual identity." Given the essentialist emphasis in this curriculum, we were concerned that students might assume that their sexual identity is something resident within them that they "discover" through some predictable process. Over 25% of 7th graders in one large urban survey said they were unsure of their sexual orientation.[20] Youth entering the 8th grade unsure of their feelings may feel relieved to hear some discussion that such feelings and experiences are common but they should not be taught that their feelings signal something definitive about their adult sexual identity. We believe the elimination of classroom discussion of personal sexual identity is a good change.

Further, we believe the guidance to teacher's concerning the source of the definition of sexual identity to be beneficial. As we point out in this paper, Advocates for Youth is an advocacy organization that opposes abstinence education and has sponsored programs promoting adolescent sexual experimentation. We hope this organization would not be considered a source for student information.

> *B. What is Sexual Identity? This term refers to a person's understanding of who* (sic) *she or he is sexually, including the sense of being male or female. Sexual identity can be thought of as three interlocking pieces: gender identity, gender role and sexual orientation. Together, these pieces of sexual identity affect how each person sees herself or himself and each piece is important: (Source: Life Planning Education, Advocates for Youth, Washington, DC, Page 125).*

The proposed changes are frequently drawn from the advocacy group AFY. Experts Shively and DeCecco include biological sex in their definition of sexual identity with which we concur.[21]

> *1. Gender Identity: a person's internal sense of knowing whether he or she is male or female. Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-34.*
>
> *2. Gender Role: knowing what it means to be male or female, or what a man or woman can or cannot do because of their gender. Some things are determined by the way male or female bodies are built. For example, only women menstruate and only men produce sperm. Other things are culturally determined. In our culture, only women wear dresses to work, but in other cultures, men wear skirt-like outfits everywhere. (Source: Life Planning Education, Advocates for Youth, Washington, DC, Page 125).*

We comment about gender identity and gender role issues below under the term "transgendered."

> *3. Sexual Orientation: the persistent pattern of physical and/or emotional attraction to members of the same or opposite sex (gender). Included in this are heterosexuality (opposite-gender attractions), homosexuality (same gender attractions), and bisexuality (attractions to members of both genders). (Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-34).*

This definition expresses an essentialist position. The definition implies an invariable persistent pattern of attractions. Other definitions have been suggested however. For instance, Byne and Parsons "use the term sexual orientation to signify a cognitive identification and subjective emotional sense of oneself on a continuum of homosexual/bisexual/heterosexual identity. This…allows for the possibility that sexual orientation may change over time."[22]

According to a new work by sexuality researcher, Ritch Savin-Williams, professor at Cornell University, most students are not now defining their sexual identity

or orientation via this essentialist manner. Dr. Savin-Williams says most teens experiencing same sex attraction do not label themselves as gay and many view these feelings as transient.[23] For the curriculum to define these terms as essential traits puts the school system in a position of proscribing a philosophical perspective concerning sexuality that is may not fit the current experience of most youth.

We have known adolescents who were told by their school counselors and/or teachers that they must be gay or lesbian because they experience attraction to the same sex. While the curriculum addresses this issue below, the situation is confused by referring to sexual orientation as unchosen. A more helpful approach would be to separate attractions from sexual identity. For most people, attractions are acquired imperceptibly and thus experienced as not chosen, whereas sexual identity is a lengthier process involving personal reflection and choice.

As noted in Section One, the definition of sexual orientation is unsettled and highly dependent upon one's philosophical position. If students are going to be able to deal intelligently with this issue, they should be exposed to both perspectives.

a. Heterosexual Or "Straight" refers to people whose sexual, emotional and affectional feelings are for the opposite gender (sex): Men who are attracted to women, and women who are attracted to men. (Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues (May 2000)).

b. Homosexual or Gay refers to people whose sexual, emotional and affectional feelings are for the same gender (sex): Men who are attracted to men; and women who are attracted to women. (Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues (May 2000).

c. Lesbian refers to women who are homosexual. (Source: American Psychological Association Online, Answers to your Questions About Sexual Orientation and Homosexuality. (July2000) http://www.apa.org/pubinfo/answers.html

d. Bisexual or "Bi" refers to people whose sexual, emotional and affectional feelings are for both genders. (Source: Id).

These definitions do not account for all people. We both have worked with people who are emotionally attracted to the same sex but sexually attracted to the opposite sex and vice versa. How would these people be labeled? We also have worked with people who do not have persistent patterns of attraction but rather have experienced change in their sexual attractions. These individuals do not consider themselves bisexual and their sexual attractions are not for both genders in any persistent manner. These definitions in the context of the entire curriculum present a picture that greatly oversimplifies the issue.

Further, there is no historical context presented for these terms. Presenting them without also noting that these terms are just over 100 years old allows students to assume that all cultures at all times have expressed modern American concepts of gay, lesbian

and bisexual. In fact, this is not the case. According to researchers, Laumann, et al, there are three common assumptions that are in their words, "patently false." They are that

1) homosexuality is a uniform attribute across individuals
2) homosexuality is stable over time
3) homosexuality can be easily measured.[24]

The proposed changes in the curriculum are based on assumptions that are considered faulty by leading researchers in the field of sexuality. We suggest a complete re-examination of these assumptions and the resultant approach to discussing sexual variations. At the very least, the health teacher should preface all definitions of sexual identities/orientations with the proviso that the task of defining sexual categories is still under study and is not settled by social scientists. See this note for possible alternatives.[25]

For Teacher Reference Only (p. 10)

Questioning refers to people who are uncertain as to their sexual orientation. (No source)

Transgender refers to someone whose gender identity or expression differs from conventional expectations for their physical sex. This term includes transsexual and transvestite. (Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-34).

The resource in the teachers' resource section by Anne Reyes is a fairly balanced definition of gender identity disorder. Teachers should make sure they are aware of that resource when questions arise concerning transgender. Many people in the transgender community do not see gender identity disorder as a disorder. Thus, teachers should take care not to normalize this experience for students who may need to be evaluated for mental health care.

Coming Out refers to the process in which a person identifies himself or herself as homosexual or bisexual to family, friends and other significant people in his or her life. (Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues (May 2000)).

Intersexed refers to people who are born with anatomy or physiology (ambiguous genitalia) that differs from cultural and/or medical ideals of male and female. (School Resource)

We are concerned that there is no definition for "ex-gay" or "former homosexual" in this line up of terms describing identities. In a recent Washington Times article concerning the controversy over the proposed changes in curriculum, school board President Sharon Cox said, "It is important for children to have facts about the way life really is."[26]If this is the case, then students should be informed that there are people who identify as ex-gay or former homosexual in the community.

II. *STEREOTYPING AND GENERALIZATIONS REGARDING SEXUAL IDENTITY (p. 10)*
A. Define stereotyping - an exaggerated and over simplified belief about an entire group of people such as an ethnic group, religious group or a certain gender

B. Examples of Stereotyping and Generalizations
1. gender role stereotyping
a. girls do the housework, boys fix cars
b. girls are better at English, boys are better at Science

Of course not all girls are better at English and not all boys are better at Science but there are group differences that show up in research. For instance, girls attain language earlier than boys and they tend to outscore boys on tests of verbal ability.[27] To foster mutual respect, there is no need to teach false information. We are surprised that these issues were not addressed in the revision.

c. girls are better babysitters than boys, boys are better at sports

These are meaningless distinctions. Objectively, there are sports where boys are better, sports where women excel and sports where gender matters little.

d. girls become nurses, boys become doctors

Perhaps, the myth would be better worded, "girls should become nurses, and boys should become doctors." Objectively, one can see gender differences in occupations. For instance, more females become elementary school teachers but this does not mean there is something non-masculine about a man teaching elementary school. However, claims such as being made here do nothing to establish the credibility of this curriculum.

2. gender identity stereotyping
a. boys don't cry, girls do
b. one sex is not supposed to enjoy activities that are culturally designated for the other sex. (e.g. boys don't enjoy talking on the phone – girls do; girls don't enjoy math- boys do)
c. boys remain calm in a crisis, girls get hysterical
d. girls fall in love, boys fall in lust

3. sexual orientation stereotyping
a. gay men are feminine – i.e. dislike sports/want to be like women
b. lesbian women are masculine – i.e. –prefer masculine attire/are tough/hate men
c. heterosexual men are masculine – i.e. like to play sports and watch them on TV
d. heterosexual women are feminine – i.e. like to dress in frilly clothing

This section is potentially confusing. Certainly not all men and women feel comfortable with stereotypic gender roles. And certainly, not all gays and lesbians are

behaviorally more like the typical opposite sex. However, nearly all biological theories of same sex attraction can be considered inversion theories, meaning gay men are viewed as having more feminine brains and lesbian are viewed as having more masculine characteristics. We would eliminate this section because it oversimplifies a very complex picture. At the least, these stereotypes should be replaced by a general statement that masculinity and femininity do not revolve around cultural stereotypes.

C. Factors That Influence Stereotyping
1. family values
2. societal generalizations and cultural beliefs
3. peers
4. media influence

D. Acceptance of Differences
1. Stereotyping promotes discrimination and prejudice and can be destructive to community.
2. The strength of American society continues to lie in the ability of people to accept and respect diversity
3. Being able to see things from another's view point promotes harmony and strength in a society.

To accept differences, this curriculum seems to want to obscure them.

III. Examine Myths and ***Facts*** About Human Sexuality <u>(The following are examples and teachers need to make sure that students understand that myths are false, and facts are true.)</u>

Myths regarding pregnancy

1. Myth: A pregnancy can't happen the first time a boy and girl have sex.
Fact: The likelihood of pregnancy depends on how close ovulation occurs to sex, whether it is the first time or not.

2. Myth: If a boy and girl do it standing up, the girl can't get pregnant.
Fact: Sperm are highly mobile and pregnancy can occur regardless of the position of intercourse.

3. Myth: A boy can't get a girl pregnant if he pulls out.
Fact: Fluid that collects at the tip of the penis during an erection may contain sperm. If this fluid enters the vagina, pregnancy can occur regardless of whether ejaculation occurs.

4. Myth: A girl can't get pregnant if she has never had a period.
Fact: Ovulation occurs prior to menstruation. Therefore, having sex before the first period can still result in pregnancy.

5. Myth: A boy can't get a girl pregnant while she is menstruating.
Fact: Although not as common, sometimes ovulation can happen at the same time or soon after a period, and pregnancy can occur.

While these points may seem premature for 8th grade students, they do respond to the observation that students seek information concerning sex behaviors before they seek information concerning disease and contraception.

We remain concerned that such information in the absence of a consistent and strong abstinence framework may embolden some adolescents to think they know enough to engage in sex safely and without consequences. We would advise changing the subjects of the myths to a "man and a woman" rather than a "boy and girl." This may seem like an insignificant change but we think it provides reinforcement for the reality that sexuality is an adult activity.

B. Myths regarding sexual orientation
1. Myth: Homosexuality is a mental health disorder.
Fact: All major professional mental health organizations affirm that homosexuality is not a mental disorder.

Homosexuality was removed as a mental disorder from the American Psychiatric Association's list of disorders in 1973. Persistent distress concerning one's sexual orientation or preferences remains a condition referenced by that group.[28] Note our concerns on pages 11-12 above about limiting the presentation of this point in isolation.

2. Myth: If you are "straight," you can become homosexual.
Fact: Most experts in the field have concluded that sexual orientation is not a choice.

This issue was addressed above in Section One. Further, the myth as stated, relates to the concept of whether sexual orientation can change (in this case from straight to gay). The purported factual response relates not to change but to choice of sexual orientation. If the definition of sexual orientation from this curriculum is used, then orientation refers to physical and/or emotional attractions. The concept of sexual attractions being unchosen does not of necessity preclude that such attractions are unchanging. In other words, the "fact" does not respond to the "myth" in this instance. In this regard, the curriculum is unnecessarily confusing. Emphasizing free will and choice is consistent with American educational philosophy.

A number of public figures have described changes in attractions (e.g., Anne Heche, Jan Clausen, Donnie McClurkin, Dennis Jernigan). Further, research has documented, even outside of a religious context, people have experienced change in their sexual attractions. For instance, Diamond (2003) described the experience of women who renounced a lesbian identity. She found that 48% of a group of 80 lesbians changed their sexual identity and attractions over a five year period.[29] Many other peer reviewed reports give evidence that various aspects of sexual orientation and identity are changeable.[30]

Simon LeVay conducted research that reported differences in the hypothalamus size of gay and straight men. While this study has not been replicated, some still point to it as evidence of a fixed trait. However, the author himself does not view sexual orientation in such a fixed manner. Along with co-author, Elisabeth Nonas, LeVay writes:

> "A person's sexual orientation is not necessarily a fixed, life-long attribute. Sexual orientation can change: for example a woman may be predominantly attracted to men for many years, and perhaps have a happy marriage and children during that time, and then become increasingly aware of same-sex attraction in her thirties, forties, or later. This does not mean that she was concealing or repressing her homosexuality during that early period. To argue that she was really homosexual all the time would be to change the definition of sexual orientation into something murky and inaccessible."[31]

Note that one of the researchers often said to have proven the genetic nature of sexuality says here that the direction of one's sexual feelings can actually change. This is not consistent with an essentialist view taken by this curriculum.

Dean Hamer has conducted research concerning the possible role of genetics in sexual orientation. His study of genetic influence has not been replicated but even with the lack of replication, he is often viewed as suggesting that sexual orientation is based exclusively in genetics. Concerning the role of genes in conscious choice, he has this to say:

> "Perhaps one of the biggest concerns for the person on the street is whether we are stuck with our genetic inheritance, or whether we can overcome our genes. "Absolutely," Hamer reassures. "One of the biggest myths is that [if] something is genetic [it] is therefore fixed. (sic) This simply isn't true. It's what we do with our genes that matters. Someone who relishes novel experiences might use this trait for good or for bad — to become a great explorer or a violent criminal. All these genes do is to give us a disposition one way or another. Whether we act on that — or don't — is very much a matter of our free will."[32]

Dr. Hamer is a champion of genetic influences for many traits from sexual attractions to religious affiliation but he is very clear that genetic influence does not mean genetic determination or that traits are fixed in the way that the typical essentialist describes.

See also the website www.queerbychoice.com for a gay oriented website that takes the position that sexual orientation is not fixed or obligatory.

The curriculum states: "Most experts have concluded that sexual orientation is not a choice." How many experts are "most?" If some experts do not agree, then why is the minority view not presented? On any other educational topic, there would be no

hesitation to present all sides of an issue. Why on this topic is standard educational practice not followed?

Secondly, this situation is more complicated than implied by this statement. Some people do consider their sexual orientation a choice and some do not.[33] Further, this statement confuses sexual feelings and sexual identity. Many experts believe same sex attractions are not consciously chosen although they may be acquired via learning. However, sexual identity is a process that is more subject to reflection and choice.

In light of this discussion, we would submit the following myth and fact:

Myth: People choose to be attracted to the same sex and thus choose to be gay or straight

Fact: Most people who gay, lesbian or bisexual do not consciously choose to be attracted to the same sex. However, adopting a gay, lesbian or bisexual identity is something that often occurs after a period of personal reflection and is as such is one option for such persons.

3. Myth: You're a homosexual if you've had sex with, or even had a "sexy dream" about someone of the same gender.
Fact: Sex play with friends of the same gender is not uncommon during early adolescence and does not prove long-term sexual orientation.

Myth: A person is a homosexual if he or she has ever been sexually attracted to, or ever had sexual contact with someone of the same gender.
Fact: Fleeting attraction or contact does not prove long-term sexual orientation.

In the April, 2005 revision, the phrase, "*sex play with friends of the same gender is not uncommon during early adolescence"* has been deleted. The revised section is a significant improvement. We believe that this will provide important clarity for youth. However, we think teachers may need more foundational information about this perspective than is supplied by the suggested teacher resources. We continue to encourage the MCPS BOE to consider including materials that will help teachers understand the differences between the essentialist and constructionist perspectives.

4. Myth: Children of homosexual parents/guardians will become homosexuals.
Fact: Having homosexual parents/guardians does not predispose you to being homosexual.

This is clearly advocacy of a political perspective. This section should be omitted.

Research concerning same sex parenting and the relationship to sexual orientation is of such poor quality that no serious social scientist could make these statements as definitive.[34] The research we do have actually points in the other direction. A study of boys and homosexual fathers shows a three times higher rate of homosexuality among

sons of gay fathers.[35] A study involving lesbian parents shows a higher rate of same sex experimentation.[36]There are differences but it is a matter of perspective whether these are positive differences or not.[37]

C. Other
1. Myth: Males have stronger sex drives and are more interested in sex than females. Fact: Female sex drive is just as strong. Society has traditionally allowed males to express their desires more openly.

The proposed curriculum vastly oversimplifies male and female sexual behavior when attempting to dispel certain myths. Regarding sexual interest, consider these statements which are related to similar vulnerabilities for each gender and significantly different styles for each gender:

a. Men are more likely to assert their sexual wishes and enforce their sexual wishes due to superior strength. Women do commit rape but it is far less often than for men.
b. Most women encourage monogamy in men and this creates a more stable family system. This is an important note as the curriculum wrongly implies that women are just as sexually interested as men. This is an error of old science and a bias toward gender neutrality.[38]
c. Men are more likely than women to engage in extramarital sex.[39]
d. Heterosexual men seem to be monogamous because those are the terms of heterosexual union and because that is what they admire about women: devotion.[40]

3. Myth: You are not really a man or woman until you have sex.
Fact: Sometimes it is more difficult to say no than yes. It is more responsible and adult-like to wait until you are ready to handle the consequences.

We agree with the inclusion of this point. We comment further below.

IV. CULTURAL AND FAMILY ***BELIEFS*** CAN AFFECT RELATIONSHIPS AND MARRIAGE (p. 11).
A. *Possible Effects of Cultural Factors*
1. arranged marriages
2. chaperoned dates
3***.*** *gender roles in household*

B. Possible Affects of Religious Beliefs
1. cannot marry outside the religion
2. children must be raised in the same religion
3. *different religions take different stands on sexual behaviors and there are even different views among people of the same religion.*

It is unclear what is to be presented here. Teachers must take care to present all sides of this matter if any sides are presented. The potential for religious students to be stigmatized is great. We are concerned that this curriculum rarely emphasizes the beneficial role of religion in developing a general set of values which have benefits for the person and the society at large. Research is beginning to demonstrate that these religious beliefs have some special health benefits for adolescents:

a. Highly religious youth living in poor urban neighborhoods are less likely to use illicit drugs than nonreligious youth living in middle-class neighborhoods.
b. As the age of children increases, religion plays a larger factor in their avoidance of drugs.
c. Young people who have good family relations, do well in school, have friends who avoid drugs and who possess anti-drug attitudes are even less likely to use illicit drugs when they are also religious.
d. The effect of religious commitment in cutting illicit drug use among poor urban teenagers is statistically significant for all categories of illicit drugs, including hard drugs.[41]
e. Youth religious involvement leads to the "ego strengths" of hope, will, purpose, fidelity, love and care.
f. Religion exerts a positive influence on youth through nine factors: moral directives, spiritual experiences, role models, community and leadership skills, coping skills, cultural capital, social capital, network closure and extra-community skills.[42]

The section that mentions the differences in beliefs about sexuality is potentially a very controversial section. Are teachers prepared to adequately handle this issue? We continue to wonder how this section will be presented and what the purpose is in including it.

C. *Other Factors That Affect Relationships*
1. education and economic status
2. family acceptance of partner/friend
3. sexual orientation of partner/friend
4. ethnicity of partner/friend

D. Examples of Problems Created by Contrasting Values/Beliefs
1. rejection
2. harassment
3. internal conflict and devaluation of the self

E. Ways to Manage Problems Created By Contrasting Values
1. Talk to someone you trust in your:
- *family*
- *school community*
- *neighborhood community*
- *religious community*

2. Seek out information to help clarify your beliefs and feelings

We think referring students who may in conflict over sexual feelings back to family, faith and friends is good advice. We remain concerned however, that in the teacher resources for sexual variations there are no materials that reflect constructionist views concerning sexual identities. In practice, if a student came to a teacher over this type of conflict, the resources available to teachers are not reflective of either a constructionist perspective or mainstream morality concerning sexuality. For those students and families that have such a worldview, this curriculum gives the health educator no assistance in responding to these needs.

Grade 8 Curriculum Resources

All resources present the essentialist view of sexuality with a heavy emphasis on genetic determinism. The authorship by professional associations should not be taken as approval by the rank and file of those organizations. In most cases, the membership of these groups do not get a voice in the publication of materials. As our citations in Section One demonstrate, there is much more uncertainty and debate surrounding these issues among researchers than is conveyed by the documents presented here.

Review of Teacher Resources

The following four resources were included in the original draft curriculum but we do not see them in the current draft. These four are written by gay rights advocacy organizations and contain various factual errors:

- Family Pride Coalition- Issues and News: Myths and Facts http://www.familypride.org/issues/myths.htm
- Lesson Plan: Sexual Orientation Myths- Planned Parenthood Association of Edmonton - http://www.ppae.ab.ca/index.php?m=1&s=11&p=2
- Teen Pregnancy Information Center-Myths About Getting Pregnant http://geocities.com/maggi19/sex/gettingpregnant.htm

Being from gay rights advocacy groups does not in itself make them inaccurate although, the myths and facts pieces contain numerous errors of fact and emphasis as we have noted. What is striking is that no advocacy organizations are recognized that take a differing viewpoint of the issues represented.

The Planned Parenthood resource includes information which favors one faith's view of sexuality over others. This seems questionable as a matter of possible religious discrimination.

The following resource is no longer available online and should be deleted:

- Recognizing Sexual Myths: National Network for Family Resiliency www.nnfr.org/adolsex/fact/adolsex_myths.html

The following resource has been deleted:

- Myths and Facts http://www.emc.maricopa.edu/diversity/glhra/mythfact.htm

The following works are not listed in the current content resource list for the 8th grade. They are produced by professional associations but primarily take the essentialist view. No resources are given that present the constructionist or developmental view. We are not sure if these resources have been deleted by they are not listed in the April, 2005 revision.

- American Psychiatric Association: Fact Sheet; Gay, Lesbian, and Bisexual Issues 1400 K Street, N.W. Washington, D.C. 20005

- Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel - http://www.apa.org/pi/lgbc/facts.pdf.

- Massachusetts Comprehensive Health Curriculum Framework- October 1999 http://www.doe.mass.edu/frameworks/health/1999/physical.html

The following resource while not peer reviewed is the most balanced and factual resource presented.

- Gender Identity Disorder, Ann Reyes - http://www.Discoveryhealth.com

SECTION THREE - Grade 10 Curriculum Evaluation

B. Factors Influencing Emotional Response
1. [*Physical/Mental*] *Biological*
a. *Innate temperament (basic foundation of personality*)
b. Hormone *levels*
c. Fatigue
d. [*General*] *Physical* health
[d. *Others*]

2. [*Cultural/Ethnic Background*] *Psychological*
a. Beliefs (about self, others, the experience or stimuli)
b. Evaluation of past experiences

3. Sociocultural
a. Expectations of one's cultural/ethnic group
b. Level of conformity to expectations
c. Impact of being a member of a minority group (e.g. racial, ethnic, sexual orientation)

In this section, sexual orientation is equated with racial and ethnic groupings. The concept of gays, lesbians and bisexual being a minority group is a common approach to achieve political objectives. Surely, the authors of this curriculum know that this viewpoint is controversial and far from determined either scientifically or politically. Why then are teachers and students expected to assume this position as a given within the context of health education?

IV. Individuality and Uniqueness

Components of personal identity
a. Self-concept: Who am I?
1) Socially
2) Emotionally
3) Cognitively
4) Physically (both physical features and health)
5) Sexually (both expression and orientation)

b. Self-esteem: How do I evaluate myself?
1) Socially
2) Emotionally
3) Cognitively
4) Physically (both physical features and health)
5) Sexually (both expression and orientation) <u>(in this context the only point to reference is how comfortable the individual feels with their role and how they are treated as a male or female – self-concept includes how you feel about yourself and how others relate to you as a male or female)</u>

c. Body image: How do I look to myself? How do I look to others?

1) Socially
2) Emotionally
3) Cognitively
4) Physically (both physical features and health)
5) Sexually (both expression and orientation)

The underlined material in the revised Grade 10 curriculum appears to address concerns we raised in our original critique. By indicating that sexual identity involves sexual expression, the curriculum implied that students would know enough about their particular sexual likes and dislikes in order to determine their self-image. We wondered how classroom discussions might develop on these points. Students can certainly reflect on their social, emotional, and cognitive styles and their physical characteristics easily. However, how can students reflect insightfully upon sexuality without engagement in sexual relations? This was another example of how the curriculum anticipates that adolescents will be involved in sexual behaviors of various types. The revised teacher guidance is a positive change.

2. Indicators of personal identity/self-worth
a. Internal, positive
1) Self respect
2) [Able] Willingness to meet challenges
3) [Able] Willingness to set and attain goals
4) Self confident

b. Internal, negative
1) Self doubt/dislike
2) Depression
3) Goal confusion, lack of efficacy

c. External, positive
1) Healthy social relationships
2) Respect for others
3) Appropriate level of risk taking

d. External, negative
1) Poor interpersonal relationships
2) Prejudice, discrimination, fearfulness toward others
3) Excessive risk taking
4) Self-destructive behaviors (i.e. tobacco, alcohol and other drugs, unprotected sex)

Referring to unprotected sex without suggesting that promiscuity is also associated with poor outcomes seems to render the abstinence message moot. Students need to know that recent data from the National Longitudinal Survey of Adolescent Health, WAVE II, 1996 has found that lower sexual activity among adolescents is correlated with higher levels of well being. In fact, sexually active girls are over three

times more likely to report depressive symptoms than their abstaining counterparts and sexually active boys are over twice as likely to report depressive symptoms.[43]

Students should know that a majority of their peers would delay sexual debut if they could. While both boys and girls experience regret about sexual initiation, girls are especially likely to say they regret their decision to become involved sexually – in a poll, 72% of girls said they wished they had waited longer to initiate sex.[44]

Certainly it seems prudent to make students aware of the research concerning increased risk for mood and anxiety disorders, STD's and substance abuse disorders. Whatever the causes of sexual early sexual behavior and variations, students who engage in early sexual behavior or experience same gender attraction should be made aware of the risks they face and the needs for intervention if necessary.

VII. Interpersonal Relationships (p. 7)
C. Influences on Peer Relationships
1. Group identity
a. A peer group is a group of similarly aged [friends sharing the same activities] people
b. [During] Adolescents peers] seek autonomy from their parents and seek social support from their peers
c. Peer groups can provide:
i. Ways to learn how to interact socially with others
ii. Assistance in defining personal identity, interests, and abilities
iii. Can provide social support and a sense of approval

2. Group pressure/manipulation
a. Peer pressure is described as the influences and pressures adolescents feel from their peers
b. Can be positive or negative
i. Positive: academic and athletic achievement
ii. Negative: [drug and alcohol abuse] pressure to do anything that you know to be wrong, do not want to do, or feel you are not ready to do
iii. Three factors that help adolescents resist negative peer pressure are self-esteem, self-confidence, and family support

3. Impact of not identifying with [a] any group may include:
a. Social withdrawal/isolation
b. Impaired school performance
c. Higher risk of absenteeism
d. Depression
e. Risky behaviors (i.e. drug abuse, smoking, alcohol abuse and risky sexual behaviors)
f. Delinquency
g. Bullying

It would have been wise to discuss the social norm approach to positive peer pressure. Students should be alerted that a minority (around one-third of adolescents aged 13-17) of students are having sex. This knowledge can help youth norm themselves.

FAMILY LIFE AND HUMAN SEXUALITY

***Note**: The section of this unit that addresses human sexuality is optional. Students under age 18 must have parental permission prior to receiving instruction. Only those outcomes noted with an (o) require parental permission. The remaining outcomes are required for all students.*

Instructional Outcomes
By the end of this course students should be able to:

- *Define terms related to human sexuality (o)*
- *Examine myths and facts of human sexuality*

Introduction to Unit: (the teacher should read or summarize the following statement at the start of the unit to alert students to what will be studied in this unit) Addressing human sexuality in an appropriate and factual fashion leads to informed teens, increasing the likelihood of students making healthy decisions. The study of human sexuality provides young adults with the knowledge and skills necessary to make informed choices. Human sexuality encompasses much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she or he will become. It includes all the feelings, thoughts, and behaviors of being female or male, being attractive, and being in love, as well as being in an intimate relationship that may or may not include physical sexual activity. During this unit we will cover five components of human sexuality.
1. Sexual Identity -- The development of a sense of who one is sexually, including a sense of maleness and femaleness. (See complete definition in IA)
2. Intimacy -- The ability and need to experience emotional closeness to another human being and have it returned.
3. Sensuality -- Awareness, acceptance of, and comfort with one's own body; physiological and psychological enjoyment of one's own body and the bodies of others.
4. Sexualization -- The use of sexuality to influence, control, or manipulate others.
5. Sexual Health and Reproduction -- Attitudes and behaviors related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behavior.
Source: Life Planning Education, Advocates for Youth, Washington, D.C., page 123
Content Outline
I. Describe Factors Contributing to Sexual Identity as Part of Personal Identity
(Please Note: the sources for the definitions are listed below for teacher use only. The definitions are to be presented to students as stated below – no additional information, interpretation or examples are to be provided by the teacher or solicited from students.)

A. What is Sexual Identity? This term refers to a person's understanding of who (sic) she or he is sexually, including the sense of being male or female. Sexual identity can be thought of as three interlocking pieces: gender identity, gender role, and sexual orientation.
Source: Life Planning Education, Advocates for Youth, Washington, D.C., Page 125.
Together, these pieces of sexual identity affect how each person sees herself or himself and each piece is important:
1. Gender Identity: a person's internal sense of knowing whether you are male or female.
Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-634
2. Gender Role: knowing what it means to be male or female, or what a man or woman can or cannot do because of their gender. Some things are determined by the way male or female bodies are built. For example, only women menstruate and only men produce sperm. Other things are culturally determined. In our culture, only women wear dresses to work, but in other cultures, men wear skirt-like outfits everywhere. Source: Life Planning Education, Advocates for Youth, Washington, D.C., Page 125
3. Sexual Orientation: the persistent pattern of physical and/or emotional attraction to members of the same or opposite sex (gender). Included in this are heterosexuality (opposite-gender attractions), homosexuality (same-gender attractions), and bisexuality (attractions to members of both genders). Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-634
a. Heterosexual or "Straight" refers to people whose sexual, emotional and affectional feelings are for the opposite gender (sex): Men who are attracted to women, and women who are attracted to men. Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues (May, 2000)
b. Homosexual or "Gay" refers to people whose sexual, emotional and affectional feelings are for the same gender (sex): Men who are attracted to men; and women who are attracted to women. Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues (May, 2000)
c. Lesbian refers to women who are homosexual. Source: American Psychological Association Online, Answers to your Questions About Sexual Orientation and Homosexuality. (July, 2003). http://www.apa.org/pubinfo/answers.html
d. Bisexual or "Bi" refers to people whose sexual, emotional and affectional feelings are for both genders. Source: same as for lesbian, above.
For Teacher Reference Only (The information in the shaded area is not to be shared with students.)
Questioning refers to people who are uncertain as to their sexual orientation. (No source)
Transgender refers to someone whose gender identity or expression differs from conventional expectations for their physical sex. This term includes transsexual and transvestite. (Source: American Academy of Pediatrics, Pediatrics, Vol. 92, No. 4 (Oct. 1993), pp. 631-634)
Coming Out refers to the process in which a person identifies himself or herself as homosexual or bisexual to family, friends and other significant people in his or her life. (Source: American Psychiatric Association Fact Sheet: Gay, Lesbian and Bisexual Issues

(May 2000)).
Intersexed refers to people who are born with anatomy or physiology (ambiguous genitalia) that differs from cultural and/or medical ideals of male and female. (School Resource)

Above, see our critique of a very similar section in the Grade 8 curriculum. The revised curriculum here includes the same restriction on use of source materials by teachers as in the Grade 8 curriculum.

Family -- The Basic Unit of Society
A. Definition: A family is two or more people who are joined together by emotional feelings or who are related to one another.
1. The year 2000 U.S. Census showed a significant increase in nontraditional households and family configurations
2. American families are becoming more complex and the greater variety of households encourages open mindedness in society

B. Kinds of Families
1. Nuclear *family*
2. Single-parent family
3. Married couple without children
4. Extended family (includes additional relatives and/or friends)
5. Blended family (remarriage with children)
6. *Same sex parents family* (This should not be interpreted as same sex marriage)
7. *Foster family*
8. *Adoptive family*
9. *Others*

This section significantly dilutes the concept of family. It ignores the historically accurate definition of family: that a family shares a blood or legal relationship. Even with the added teacher guidance (This should not be interpreted as same sex marriage); the BOE takes sides in the cultural debate over gay marriage with the addition of "same sex parents family."

The curriculum can note the existence of nontraditional families but do so in a way that does not seem to advocate for a particular political stance. We would eliminate point A.2 above (*American families are becoming more complex and the greater variety of households encourages open mindedness in society)* as a means toward that end. The curriculum is putting a positive slant on one political viewpoint that is hotly disputed among social scientists as well as the public at large. Many experts and lay people alike believe that many family forms may share a common bond of love, but that the traditional family has the most social science support it as an effective vehicle to raise children and guarantee the protection of women.[45] While there are people of good will on both sides of this issue, it seems inappropriate for the school to become an advocate of a political position on this extremely sensitive issue.

Grade 10 Curriculum Resources

Our original observations about these resources are similar to those concerning the Grade 8 resources. Two of the seven resources originally listed were advocacy articles with the remaining five solidly behind the essentialist position concerning sexual orientation. However, the currently approved resources listed in the curriculum seem to be more balanced toward a variety of views, including abstinence.

The materials on bullying and violence are potentially valuable, especially if applied to all students.

One critical observation is that the resources concerning bullying conveys the erroneous impression that if you have moral concerns about homosexuality or you do not favor the essentialist position then you may be contributing to the problem of harassment and violence. We certainly believe in respect and safety for all students but believe that it is possible to properly report and interpret the research concerning sexual orientation. Disagreement with a person's viewpoint or lifestyle choices does not imply disrespect or hatred of the person. This point is not made clear and as such may represent a bias against those who have traditional views concerning sexuality.

Furthermore, some of the resources present religious information and seem to supports one religious perspective over others. We wonder why the MCPS would put the district in a position to give students religious advice that favors some faiths over others. Such materials could be construed as religious discrimination toward those students, parents and faculty with traditional religious perspectives concerning sexuality.[46]

We are pleased to see that the revised curriculum retains several good resources concerning abstinence and decision making.

SECTION FOUR – Summary and Suggestions

The following points summarize our assessment of the MCPS proposed curriculum changes:

- The curriculum on contraception unnecessarily presents some material that may serve to promote sexual activity. Since adolescent sexual behavior is correlated with numerous negative outcomes, providing material that encourages sexual behavior seems counterproductive.

- The curriculum on same gender attraction is based on a theoretical orientation, called essentialism, which does not represent a singular consensus of opinion in the social sciences and research community concerning sexual orientation.

- Some very controversial issues and matters of debate within the psychological and medical communities were presented as settled facts.

- The essentialist assumptions in this curriculum undermine an important basic human trait: free will and choice. Historically, this has been a critical educational value for educators, administrators and parents.

- The curriculum does not adequately inform educators about how to prepare children who may have same gender attraction for the additional risks they may encounter: higher levels of mental illness and substance abuse, higher levels of STD's.

- The curriculum wrongly assumes that harassment of gays and lesbians will be ameliorated through this educational process. Although a worthy and necessary objective, to date there are no data to support such an assertion. On the contrary, there is evidence to suggest that the distress of gay and lesbian identified students may continue despite such efforts.

- The curriculum does not explore in depth the educational, financial and mental health benefits associated with sexual abstinence for teenagers.

- The curriculum appears to view with suspicion and/or neglect the role of religious beliefs in assisting some adolescents to make healthy decisions.

- The curriculum uses as sources documents provided by advocacy organizations. These advocacy organizations have a political agenda which undermines the educator's ability to present sound information to their students. Furthermore, curriculum resources completely omit scientific information, published in peer reviewed journals, which differ from the positions of these political advocacy organizations.

The curriculum could be more aptly titled: Presenting a Value Free, Essentialist Perspective on Human Sexuality. The key word here is perspective. If this material were presented as part of a debate class, or even as an article in the school newspaper it would be understood that it was just one point of view. When the MCPS presents a biased approach to teach children about sexual behavior, children will assume that the information is scientific and balanced. Restricting information to a biased point of view interferes with a full presentation of options are available to students in setting their life goals and managing their personal behavior to reach those goals. This approach seems completely contrary to the mission of the Montgomery County Public Schools.

In addition to the suggestions for revision made throughout this paper, we continue to recommend the following:

- The curriculum should be returned to the CAC for further revision. According to coordinator Russ Henke, the entire curriculum is undergoing revision. We suggest that this section be returned to that process without further field testing.

- The BOE should consider the possibility that researchers and experts representing a diversity of research perspectives be called in to assist in making the curriculum better represent current thinking in sexuality education. In this way, parents and the BOE can return focus to the important mission of providing Montgomery County students the best possible education.

We add one recommendation to this revised evaluation:

- Based on our review of the condom demonstration video, Protect Yourself, we recommend that the video be pulled from field testing. The errors of fact contained in the video make it unsuitable for classroom use. (See Section Five, page 38 for the video evaluation)

Changes being considered in this curriculum will impact a generation of students in the Montgomery County schools but will also have repercussions across the nation. We urge the MCPS BOE to consider these recommendations.

SECTION FIVE – Evaluation of the video Protect Yourself

By: Warren Throckmorton, PhD, Ruth Jacobs, MD & David Blakeslee, PsyD

Our task here is review the video, Protect Yourself, for accuracy. We have already expressed our concerns about the use of a condom demonstration with all 10th grade students. However if such a video is to be used, it must contain no factual errors and provide comprehensive information concerning risks. This video does not meet those requirements.

As a general comment, the video is well done and the narrator gives a good performance and so our critique of the video is primarily meant to reflect on the content and organization of the video.

The errors that disqualify the video from educational use include:

1. The video recommends condoms using the spermicide nonoxynol-9 for oral, anal and vaginal sex. This recommendation is directly contrary to the WHO guidelines regarding Nonoxynol-9. Significant adverse reactions caused by nonoxynol-9 include irritation of mucous membranes which could be a cofactor to promote transmission of STIs including HIV.

2. The video says the condoms are 98% effective and gives the impression that this is for both pregnancy and STI reduction. The video confuses the issue by not saying for what outcome condoms are 98% effective. Condoms are nowhere near 98% effective for STIs, especially herpes and HPV and in fact are much lower.

3. It is true that condom failure rates approaching 2% have been reported with perfect use for pregnancies in groups of women that include older, mature females. However, typical condom use failure rates for pregnancy are estimated to be 15%.[47] Typical use is defined as inconsistent and imperfect use which is more like how adolescents use condoms even with instructions. Withholding this information is irresponsible

4. The video contains no disclaimer regarding the inability of a video to properly instruct teenagers in perfect condom use. Without stronger warnings that perfect use is unlikely for teens, the 98% figure used by the video could easily give teens a false sense of safety.

5. The video mentions oral and anal sex without providing risk disclosure of such activities. The video states, "Remember to use a condom for oral, anal and vaginal sex." This advice is stunning in itself in that oral, anal and vaginal sexual relations are lumped together as if the risks in these practices were equivalent. The increased risk of STIs with anal sex is ignored by the video.

Significant errors of fact and emphasis exist in this video. Furthermore, the video systematically exaggerates the benefits of condom use in direct conflict with established data and recommendations from the CDC and WHO. Parents and the consumers of this information, students, are right to oppose the presentation of this video in its current form.

Based on the errors of emphasis and fact, we strongly recommend that this video be removed from use in MCPS.

Video Evaluation

The first visual images are of condoms on the screen. The title of the movie, Protect Yourself comes on screen with pictures of condoms randomly distributed on the screen. Clearly, this video is about condom usage.

The young, female narrator opens in the condom section of a pharmacy with condoms in the background. This background remains as a backdrop throughout most of the film. She opens with the monologue:

"So how will you know what you are doing wrong, if you aren't informed about how to protect yourself? In the next few minutes, you'll learn about how to protect yourself from unplanned pregnancies and SDIs, including HIV. Now today we are going to talk about latex condoms (close up of condom display). But we all know what the best way to protect ourselves is…"

One could get the impression that the film is about condoms as the best means of protection from STIs and pregnancy. The coming mention of abstinence seems like a peripheral idea.

The camera changes to an outdoor pool area and man on the street interviews with teens. The narrator asks: "What is the best way to protect yourself from sexually transmitted infections and unwanted pregnancies?"

Boy: "Well, I guess that would be abstinence."

Girl: "To use condoms or not to do it."

Girl: "That would probably be to use a condom or maybe something else?"

Narrator: "What do you think the best way is to protect yourself from sexually transmitted infections and unplanned pregnancies?"

Boy: "Um, condoms and abstinence."

Boy: "Using abstinence."

Boy: “With a condom”

Girl: “Abstinence”

Girl: “The best way is not to have sex at all.”

Boy: “Condoms”

After the adolescents filmed have revealed their confusion over the issue, the narrator reappears back in the pharmacy and says, “Maybe we don’t know. Maybe it seems like a trick question. But the answer is, the best way is to protect yourself from getting an STI or having an unplanned pregnancy is by not having sex at all. Abstinence is 100% effective (graphic appears on the screen with these words and the condom display in the background) and no other method works as well (close up of condom packages).”

This approximately 18 second reference to abstinence is good and factual but it seems odd and counterproductive that pictures of condoms appear on screen as the narrator notes the effectiveness of abstinence. Without doing a survey, it is hard to know for certain what message is being communicated here. However, it is worth noting that the students surveyed in the film were confused about abstinence and the best way to avoid disease and pregnancy.

Condom Effectiveness and Pregnancy

The narrator continues, “Well why does everyone always talk about condoms? A condom works as a barrier during sex and is the only method that protects you from both STIs and unplanned pregnancies. The pill and the patch can’t help you when it comes to STIs and HIV (close up on birth control pills). So if you are sexually active now or will be in the future, it’s important to always use latex condoms. So just how effective are condoms? When used correctly and consistently, condoms can be about 98% effective. (scene repeats) When used correctly. When used correctly. When used correctly.”

When the video declares a 98% effectiveness, there is no context given for this figure. It is not clear if the video is talking about pregnancy prevention, disease prevention or both. This is no small distinction as the rates of effectiveness are much better for pregnancy prevention than for disease. Teens making decisions about how to protect themselves need to know these facts.

Regarding pregnancy prevention, the video quotes an estimate based on perfect condom use which is define as error free use during every sexual experience. Furthermore, nearly a quarter of the women in the study sample were over 30 years old.[48] These characteristics cannot be generalized to 10th grade students. Consider this quote from the Advocates for Youth (an advocacy group frequently quoted in the revised curriculum). They write:

> With typical use, 14 percent of women relying only on the male condom, and 21 percent relying only on the female condom, will experience unintended pregnancy within one year. With perfect use (meaning couples make no errors in the way they use the condoms and also use condoms consistently at every act of sexual intercourse), only five percent of women relying on the male condom, and three percent on the female condom, will experience unintended pregnancy within one year.[49]

Other studies have produced similar findings. In a 2004 review of contraceptive use in the Journal of Contraception, it was reported that 15% of women experienced an unintended pregnancy over the course of one year with typical condom use and 2% became pregnant with perfect use.[50]

Note the differences in rates of pregnancy between perfect and typical condom use. The video does not mention female condoms at all, nor does it give pregnancy rates for very inexperienced users. Does the MCPS BOE think showing this video one or two times will result in teens who are proficient condom users? There are no warnings in the video that alcohol/drug use can increase condom use errors. Given the fact that such substance use is more likely among sexually active teens, the video is remiss in not presenting this risk factor. Students need to know that the actual rates of risk for them are much higher than quoted by the film.[51]

In short, this video quotes rates of condom effectiveness for pregnancy prevention that are too high even with perfect usage. It seems inevitable that such false information will encourage a false sense of security among sexually active teens.

Condom Effectiveness and STIs

No study that we could locate reports rates of effectiveness as described in the video for any STI. On the contrary, many STIs can be spread even with perfect condom usage and this not mentioned at all in this video. According to a report in the American Journal of Obstetrics and Gynecology, the "condom barrier protection provides little protection from the "SS" ("skin-to-skin" and "skin-to-sore") transmission of STDs such as HPV, HSV, syphilis, lymphogranuloma venerum (LGV), or chancroid."[52] This is a highly alarming oversight and one that by itself should invalidate the use of the video.

For instance, human papilloma virus (HPV) infection can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Although condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease, the rates of protection are unclear.[53]

The 98% figure is inconsistent with the National Institutes of Health 2000 Consensus Report on condom usage. The NIH report confirms that there is no protection provided by condom use for HPV transmission, and that protection provided by condoms from many sexually transmitted diseases such as gonorrhea or Chlamydia transmission from men to women and genital herpes, trichomoniasis, chancroid or syphilis is in fact

undefined. Whether or not condoms protect against herpes is very controversial. The NIH report confirms that protection provided by condoms from the HIV virus is only 87% for vaginal sex. This statistic does not apply to rectal sex and we do not know very much about the risks of transmitting HIV via oral sex, except to say we know it occurs.[54]

Concerning herpes, a 2004 report from the World Health Organization notes that HSV-2 (herpes simplex virus 2) was acquired even by people who reported using condoms during 100% of sexual activity.[55] This WHO report also updates the NIH Consensus Report concerning HPV. The authors state, "A meta-analysis of 20 studies found no evidence that condoms were effective against genital HPV infection. Neither of the two prospective studies reviewed found that consistent condom use was effective in preventing genital HPV infection or HPV related conditions."[56] Concerning the gamut of STIs, an Australian and New Zealand Journal of Public Health report says, ""Condoms offer some protection (30-90%) against STIs passed in semen, urethral, vaginal or cervical secretions (such as HIV, gonorrhea, chlamydia). *They offer little or no protection (0-30%) against diseases due to skin-to-skin contact such as genital herpes (HSV2) and genital warts (HPV)."*[57] (emphasis added).

Consistent condom use does indeed lessen the risk of contracting a STI but even with perfect use, the risk is significant. For instance, a study of African-American teens shows even among girls whose partner used condoms 100% of the time, 17.8% had at least one STI compared to 30% of girls who did not require partners to use condoms during each sexual episode.[58] The video gives the viewer no information regarding the real risk of contracting STIs, even with perfect condom use. *This lack of information makes this video inadequate for use in any health curriculum.*

Condom Usage and Nonoxynol-9

The video then moves into a section designed to give advice about how to purchase and use condoms properly. The narrator introduces the section by saying, "Most of the time though, people aren't using them the right way. So how hard can it be you think? It doesn't seem like rocket science. But there is a right and wrong way for doing anything." What follows is some accurate information concerning the proper use of latex condoms such as do not open the package with teeth, be careful not to tear the condom with fingernails, and do not keep condoms in a car or wallet where heat can cause damage.

Additional tips in choosing condoms are provided such as make sure the condom is latex, has a reservoir tip and is not older than the expiration date suggests. Lubricated condoms are suggested to prevent breakage. Students are told to never use oil based lubricants but rather water based kinds, such as KY Jelly.

The video takes a serious factual wrong turn with the next recommendation. The narrator says, "…look for condoms with spermicide, like nonoxynol-9. We used to think that nonoxynol-9 was effective in neutralizing HIV and other STIs but recent research

has shown that it is not. However, condoms used with spermicide are effective in neutralizing sperm which reduces the risk of unplanned pregnancies."

The recommendation of condoms using nononxynol-9 is contrary to recommendations from the World Health Organization published in 2001. These WHO research based recommendations are as follows:

- Although nonoxynol-9 has been shown to increase the risk of HIV infection when used frequently by women at high risk of infection, it remains a contraceptive option for women at low risk.
- Nonoxynol-9 offers no protection against sexually transmitted infections such as gonorrhoea or chlamydia.
- There is no evidence that condoms lubricated with nonoxynol-9 are any more effective in preventing pregnancy or infection than condoms lubricated with silicone, and such condoms should no longer be promoted.
- Nonoxynol-9 has been shown to cause epithelial (tissue) disruption in the vagina and rectum.
- Nonoxynol-9 should not be used rectally.[59]

Note that the WHO recommends nonoxynol-9 condoms not be promoted. Perhaps this is because nononxynol-9 has been demonstrated to cause skin lesions in the vagina, mouth and anus. Recent studies have raised the concern that these lesions actually promote the spread of certain STIs. For instance, nonoxynol-9 has been shown to increase the transmission of herpes (HSV) via tissue disruption.[60]

Some manufacturers have voluntarily pulled products with nonoxynol–9 due to concerns that the substance may further the spread of the HIV virus. In June 2001, the CDC recommended that nonoxynol-9 not be used as a microbicide or lubricant during anal intercourse.[61]

Use a condom for oral, anal and vaginal sex

After a demonstration of how to put a condom on a cucumber, the narrator says, "Remember to use a condom for oral, anal and vaginal sex." This advice is stunning in itself in that oral, anal and vaginal sexual relations are lumped together as if the risks in these practices were equivalent. In a video that aspires to educate 15 year olds, it is irresponsible to introduce talk about various forms of sexual activity and not differentiate between the risks associated with each activity. Again, the authors exaggerate benefits, and either minimize or ignore real risks.

The reference to anal sex is especially troubling given the recommendations from the WHO and the CDC **not** to use nonoxynol-9 products while engaging in this practice. Furthermore, nonoxynol-9 should not be used orally. The advice to use condoms with nononxynol-9 for anal and oral sex is completely antithetical to current best practices and may lead to dangerous behavior on the part of sexually active teens.

Warning labels on the Trojan brand of condom carry these cautions: "Spermicidal lubricants are not for rectal use or more-than-once-a-day vaginal use" and "Any use of Trojan Brand Latex Condoms for other than vaginal intercourse can increase the potential damage to the condom."[62] A full discussion of the increased risks of anal sex versus vaginal or oral sex is beyond the scope of this critique but they are substantial and recommending condoms without an examination of the special risks of the practice is irresponsible.

Troubling also is the fact that the teacher's guide and student work sheet focus on knowledge of nonoxynol-9 as one of the crucial objectives in viewing this video. Thus, the misinformation here is not an insignificant matter. *The MCPS should pull this video from use and revamp the lesson plan and student handout to reflect knowledge and best practices.*

Get Consent

The video makes an important point here. The narrator makes a clear statement concerning consent for sexual relations that should be a part of any video concerning sexuality. The narrator says, "Here is the part where it really counts so listen up. Remember to always get consent before becoming sexually active in any way. This means getting a verbal yes to any kind of sexual activity from your partner before anything happens. Oh, and if you think it's too embarrassing to talk about then maybe you shouldn't be doing it."

The video closes with a very weak disclaimer concerning the significant risks of contracting STIs, even with condom use. We believe that this is much too mild to have any impact, especially in light of the fact that the video tells students that condoms are 98% effective. The narrator closes by saying:

"It's also important to remember that there are risks in using condoms. You may be allergic to latex in which case, you may want to explore polyurethane condoms. Condoms may also be defective and have microscopic holes. If you're concerned about the risks or reliability of condoms, just remember the best way to protect yourself is abstinence (close up of condom boxes on screen). However, if you are sexually active in any way, latex condoms when used correctly, are your best protection against STIs, including HIV and they help to prevent unplanned pregnancies. Lastly, if you are sexually active, it's important that you protect yourself, and you can do that when you know how to use a condom correctly."

CONCLUSION

No matter how well intentioned the planners and makers of this video were, this effort could actually place students at risk for contracting STIs and, to a lesser degree, having an unplanned pregnancy, due to false information and false assurances.

For the reasons we have documented, we urge the MCPS BOE to discontinue usage of this video. We believe the curriculum and any video concerning contraception must take into account the issues have raised in this evaluation as well as a focus on primary prevention of risky sexual behaviors.

ENDNOTES

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[2] E.g., under "Safety, First Aid and Injury Prevention" Content Outline for Grade 10, Under point IIB (Negative risk taking behaviors), "high risk sexual behavior" is listed instead of premature sexual behavior or promiscuous sexuality. Students may assume that the adults believe it is fine to be involved in sex as long as it is "safe."
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sexual attractions are primarily to others of the opposite sex. Straight is a common term to describe someone who identifies as heterosexual. **Homosexual** – Persons whose current sexual attractions are primarily to others of the same sex. Gay (men) and lesbian (women) are common terms to describe those who identify as homosexual. **Bisexual** – Persons whose current sexual attractions are for members of both sexes. **Asexual** – Persons who currently do not experience strong sexual feelings toward either the same or opposite sex. Not all people use a label to describe their sexual feelings. Some people feel that they have shifted sexual feelings from gay to straight or straight to gay. **Ex-gay** is a common term used to describe someone who feels they have changed from being gay to being straight.

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[61] Syphilis and MSM – http://www.cdc.gov/std/STDFact-MSM&Syphilis.htm#prevent.
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APPENDIX B - Suggested Resources

The following resources provide perspectives and information missing from the current curriculum and teacher resources. This list is by no means exhaustive but gives a sampling of literature that could more completely inform educators concerning the diversity of perspectives and research in sexual orientation.

- Abstinence.net – Website of the Abstinence Clearinghouse with research and commentary concerning abstinence based sexuality education.

- Blakeslee, D. & Throckmorton, W. (2004). Sexuality Myths and Facts - http://www.drthrockmorton.com/article.asp?id=110

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