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Commentary

Beyond Abstinence and Risk: A New Paradigm for Adolescent Sexual Health

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Two paradigms have shaped how U.S. policy makers, health professionals, and educators have approached teenage sexuality over the past several decades. The first is the abstinence-only-until-marriage paradigm, according to which sex outside of heterosexual marriage is always wrong and harmful (Santelli et al., 2006). The second is the sex-as-risk paradigm, which defines adolescent sexuality in terms of risk and risk taking (Michaud, 2006). The two paradigms share a near-exclusive focus on acts of teenage sexual intercourse, conceptualize such acts as dangerous, and assume that emphasizing their risks is the way to help young people become sexually healthy. Both paradigms exemplify what I call the dramatization of adolescent sexuality: They highlight internal conflicts—between impulse and cognition—and interpersonal conflicts—between boys and girls and between youth and parents (Schalet, 2004).

But these two paradigms give us only limited tools to conceptualize and promote positive adolescent sexual development and relationships. First, by defining teenage sex as wrong or risky, they insufficiently distinguish sexual acts that are quite safe from those that are high risk. Second, by viewing sexuality as an “either/or” activity rather than a continuum, they give scant attention to the skills—including those necessary to discern and communicate sexual wishes and boundaries—that allow youth to explore sexuality in a gradual, intentional, and pleasurable fashion. Third, they do not pay enough attention to the relationships—with partners and adult caregivers—that can support positive adolescent sexual experiences. Finally, they often fail to recognize the socioeconomic deprivations that are at the root of many negative sexual health outcomes and must be addressed to foster healthy development.

We see the limits of these two paradigms more clearly when we look outside our national borders at countries that have approached teenage sexuality differently. The teenage fertility rate, for example, is eight times lower in the Netherlands than it is in the United States, and the teenage abortion rate is more than twice as low, despite comparable ages of sexual initiation in the two countries (Kost, Henshaw, & Carlin, 2010; van Lee, van der Vlucht, Wijsen, & Cadée, 2009). One important reason for the difference is that Dutch youth are more likely than their American peers to use reliable methods of contraception—most notably the pill and dual protection—and to do so from first intercourse onward (Abma, Martinez, Mosher, & Dawson, 2004; Ferguson, Vanwesenbeeck, & Knijn, 2008). Notably, most Dutch teenagers report that their first sexual experiences—broadly defined—are well-timed, wanted, and fun, whereas many American teens say they wish they had waited longer to have sex, suggesting that the former feel more control over and more entitled to sexual exploration (Albert, 2004; de Graaf, Meijer, Poelman, & Vanwesenbeeck, 2005).

A host of economic, political, and cultural factors contributes to these differences: Dutch youth are less likely than their American counterparts to grow up in the poverty that fosters early childbearing, to lack formal education on contraception, and to encounter financial or emotional barriers to obtaining contraceptive and abortion services. And although sexuality remains a difficult topic to broach in most American families and is a source of disconnection between teenagers and parents, most Dutch parents accept sex between teenagers when they are in are steady relationships and using contraception, and permit such couples to spend the night together at home (Schalet, in press). Adult acceptance of adolescent sexuality makes it easier for teens to recognize that they are sexual beings, plan sexual acts, negotiate sexual interactions, and ask for assistance when they need it.

Creating the conditions for more positive sexual experiences and outcomes among adolescents in the United States requires both political will and cultural innovation. Offered here is an alternative model for adolescent sexual health: this ABC-*and-D* directs attention to the fundamental skills, relationships, and resources that youth need to develop as healthy sexual and emotional beings. The *A* in this conceptual model refers to *autonomy* of the sexual self. We know that adolescents acquire new skills for autonomy, but this premise is rarely applied to sexuality. Gaining sexual autonomy involves knowing about sexual desire and pleasure, recognizing and articulating sexual

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wishes and boundaries, and learning to anticipate and prepare for sexual acts. When youth have sexual autonomy, they can recognize their sexual feelings as separate from the desires and pressures of others, own their feelings, and exercise control over their sexual decision making (see also Tolman, 2002). Acquiring such autonomy is easier when youth move slowly in sex, assessing their desires and comfort levels at every step before moving to the next.

A sense of sexual autonomy helps youth to navigate sexual interactions: Teens who have a greater sense of control in sexual situations are more likely to refrain from intercourse and use condoms when they have sex (Pearson, 2006). When girls report more sexual subjectivity—body esteem, entitlement to pleasure, and sexual self-reflection—they experience greater self-efficacy in condom use (Horne & Zimmer-Gembeck, 2006). And girls who report more sexual self-efficacy—ability to act on their sexual needs—are more likely to have used condoms at first intercourse (Impett, Schooler, & Tolman, 2006). Boys also need to be bolstered in their autonomy so they are better equipped to resist rigid masculinity norms, which—like rigid femininity norms—can undermine contraceptive use and sexual health (Pleck, Sonenstein, & Ku, 1993).

Building good romantic relationships (*B*) is a second critical component of healthy sexual development. Our current paradigms often place teenage sexuality outside the context of the relationships in which it is expressed. Or they reference two relationship archetypes: The heterosexual marriage ideal on the one hand and the risk of the abusive relationship on the other. But rather than uphold marriage as the only valid relationship, we must validate adolescents' need for intimacy and assist them in building egalitarian and nourishing romantic relationships suited to their life stage. And rather than teach about healthy relationships primarily through the lens of *unhealthy* relationships, we must give equal weight to the characteristics of positive romantic relationships and the skills necessary to build them. Components of such positive, age-appropriate relating include getting to know another person, building trust over time, dealing well with conflict, striving for power equality, and having fun.

Good romantic relationships build positive sexual health outcomes. Parents and health and education professionals tend to be wary of romantic relationships between teens because such relationships can lead to sexual intimacy. But it may be more important to identify the critical characteristics of teenagers' romantic relationships: Adolescent sexual activities are more likely to be safe, wanted, and gratifying when relationships are equal—that is, not characterized by large age differences between girls and older boyfriends—and when teenagers feel satisfied, experience intimacy, and are able to discuss contraception openly within their relationships (Houts, 2005; Manlove, Ryan, & Franzetta, 2007; Stone & Ingham, 2002; Widman, Welsh, McNulty, & Little, 2006).

Third, adolescent sexual health requires *connectedness* with parents and other caregivers (*C*). Parental communications about sex can have positive health effects when the relationship between parent(s) and teenagers is close, communication is frequent, and teenagers see their parent(s) as open, skilled, and comfortable (Martino, Elliott, Corona, Kanouse, & Schuster, 2008; Whitaker, Miller, May, & Levin, 1999). In fact, connectedness between parent(s) and teenagers often breaks down over the issue of sex, with parents' conveying foreboding messages and teenagers hiding sexual activities. Health professionals, educators, clergy, and even those who work in media must help parents and teens bridge this connectedness gap.

The final components of the ABC-*and-D* conceptual model concern the two *D*s: Recognizing *diversities* and removing *disparities* in access to vital socioeconomic resources. Teens are diverse in the pace of their sexual and emotional development, in their sexual orientations and gender identifications, and in the cultural values that shape their perceptions and experiences of sexuality. Education and health policies must honor these diversities and teach youth to respect their own distinctiveness and that of others. But respecting difference is not the same as accepting disparity. Many negative adolescent sexual health outcomes result from lack of services and opportunities for quality education and jobs. Poverty directly and indirectly undermines many aspects of healthy sexuality—including feelings of control over life and contraceptive use. Ensuring that teens and their families have access to basic resources is therefore essential to adolescent sexual health.

Implementing this ABC-*and-D* framework involves guaranteeing youth access to comprehensive sexuality education and health services. But it also requires that policy makers expand education and health aims beyond delay and disease and pregnancy prevention to include the skills, relationships, and resources youth need for a healthy sexual development. Researchers must likewise broaden definitions of and agendas for adolescent sexual health research. Providers and educators must address adolescent sexuality from the perspective of young people's individual and diverse developmental trajectories and relate their sexual development to their broader emotional and relational development. Bolstering teenager–caregiver connectedness during adolescent sexual and relational development, helping parents to acquire more effective tools for communication, and empowering youth to confide in and seek assistance from trusted adults when they need to should be overarching goals.

By bringing the positive components of adolescent sexuality into view—pleasure, intimacy, and discovery—this ABC-*and-D* framework does not deny sex's potential dangers. Rather, the new paradigm expands the tools and templates available to address those dangers: Young people who have access to the basic necessities of life and who have developed the sexual self-knowledge and self-regulation necessary to exercise sexual autonomy are much better equipped to make intentional and respectful choices about when and how to engage in sex. And when providers and educators place sex in the context of adolescents' intimate relationships—sexual and nonsexual—they may be better able to aid youth in critically assessing those relationships and to establish the rapport needed to facilitate teen disclosure about violation and coercion. Finally, foregrounding the healthy aspects of sexuality and relationships encourages youth to formulate their own positive visions and expectations.

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