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# Sexuality Education and Desire: Still Missing after All These Years

MICHELLE FINE  
SARA I. MCCLELLAND

*The Graduate Center, City University of New York*

*Nearly twenty years after the publication of Michelle Fine's essay "Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire," the question of how sexuality education influences the development and health of adolescents remains just as relevant as it was in 1988. In this article, Michelle Fine and Sara McClelland examine the federal promotion of curricula advocating abstinence only until marriage in public schools and, in particular, how these policies constrict the development of "thick desire" in young women. Their findings highlight the fact that national policies have an uneven impact on young people and disproportionately place the burden on girls, youth of color, teens with disabilities, and lesbian/gay/bisexual/transgender youth. With these findings in mind, the authors provide a set of research guidelines to encourage researchers, policymakers, and advocates as they collect data on, develop curricula for, and change the contexts in which young people are educated about sexuality and health.*

Michelle Fine's (1988) article "Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire" was published in the *Harvard Educational Review* almost twenty years ago. In that essay, Fine questioned the ways in which schools taught young people about sexuality. She argued that schools, by positioning young women primarily as potential victims of male sexual aggression, seriously compromised young women and men's development of sexual subjectivities. The capacity of young women to be sexually educated — to engage, negotiate, or resist — was hobbled by schools' refusal to deliver comprehensive sexuality education. The power of this argument lay in naming the relationship between the absence of sexuality education on desire and the presence of sexual risk:

The absence of a discourse of desire, combined with the lack of analysis of the language of victimization, may actually retard the development of sexual subject-

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tivity and responsibility in students. Those most “at risk” of victimization through pregnancy, disease, violence, or harassment — all female students, low-income females in particular, and non-heterosexual males — are those most likely to be victimized by the absence of critical conversation in public schools. . . . Public schools constitute a sphere in which young women could be offered access to a language and experience of empowerment. . . . “Well educated” young women could breathe life into positions of social critique and experience entitlement rather than victimization; autonomy rather than terror. (pp. 49–50)

Educated as neither desiring subjects seeking pleasure nor potentially abused subjects who could fight back, young women were denied knowledge and skills, and left to their own (and others’) devices in a sea of pleasures and dangers. Even before Fine’s article, but especially in the two decades since, feminist scholars, educators, and activists have voiced concern about the missing discourse of female desire (see Rose, 2003; Snitow, Stansell, & Thompson, 1983; Tolman, 2002; Vance, 1993).

Today we continue to worry. Our worries, however, stretch to include the severe and unevenly distributed educational and health consequences of the federal education campaign promoting abstinence only until marriage (AOUM). This educational crusade has been unleashed through public institutions and laws advocating the virtues of abstinence, the dangers of unmarried sex, and the promised safety of heterosexual marriage.

This article focuses on sexuality education through the window of the federally funded AOUM movement. Using federal abstinence guidelines, interviews with sexuality educators, visits to abstinence-only conferences, conversations with youth in schools, and evaluations of abstinence curricula, we critically analyze the history of AOUM policies and the consequences of AOUM for distinct groups of young women living and desiring at the embodied intersections of gender, sexuality, race, ethnicity, class, and disability. We draw from a larger project we have undertaken that focuses on the role the courts, schools, and states play in infringing on young women’s sexuality via parental consent mandates, AOUM curricula, and emergency contraception battles (see Fine & McClelland, *in press*). The sexual subjectivity of young women remains our focus in this discussion because their bodies bear the consequences of limited sexuality education and are the site where progressive educational and health policies can have significant effect.

### Contemporary Analysis of Sexuality Education

Adolescent desires develop within the context of global and national politics, ideologies, community life, religious practices, and popular culture; in family living rooms, on the Internet and on MTV; in bedrooms, cars, and alleys (Douglas, 1966; Foucault, 1988; Phillips, 2000). We situate our analysis of adolescent sexuality education within a human rights framework, allied with

struggles over reproductive rights, political economy, health care, education and prison reform, structural and personal violence (see Correa, 1994; Correa & Petchesky, 1994; Impett, Schooler, & Tolman, in press; Luttrell, 2002; Nussbaum, 2003; Petchesky, 2005; Roberts, 2002; Sen, George, & Ostlin, 2002; Sen, 1994; Tolman, Striepe, & Harmon, 2003; Zavella, 2003).<sup>1</sup>

We understand further that while all young people, by virtue of age, depend on the state and develop under state regulations, the adverse consequences of state policies that curtail education and health are not equally distributed. In fact, national policies concerning sexuality fall unevenly on girls, poor and working-class youth, teens with disabilities, Black and Latino adolescents, and lesbian/gay/bisexual and transgender youth.

By considering national sexuality education policy and young women's access to contraception and abortion, it is fair to say that young women's sexuality has become a designated "dense transfer point for relations of power" (Foucault, 1990, p. 103). We focus here on young women's sexual encounters with the state — through law, policy, and public institutions — as "the best hidden things in the social body" (p. 118). Young women's sexual relations with the state offer a window onto the intimate implications of neo-liberalism and fundamentalism.

While early seeds of the abstinence movement can be traced back to the 1981 Adolescent Family Life Act (AFLA), and followed up fifteen years later by the Personal Responsibility and Work Opportunity Reconciliation Act signed into law by President Clinton in 1996, the contemporary AOUM campaign marks a moment when social policy, ideology, and educational practice are being aligned for abstinence, for heterosexual marriage, and against critical education about power, desires, or dangers. Put differently, in the language of Antonio Gramsci, today we witness varied public institutions deployed in a "passive revolution" for abstinence:

The category of "passive revolution". . . qualify[ies] the most usual form of hegemony of the bourgeoisie involving a model of articulation whose aim is to neutralize the other social force . . . enlarging the state whereby the interests of the dominant class are articulated with the needs, desires, interests of subordinated groups. (Gramsci, 1971, as cited in Mouffe, 1979, p. 192)

This process accelerates, Jovchelovitch (2001) argues, when arenas for public conversation close, when spaces for dissent are infiltrated by surveillance or threats, and when the "fizz of dialogue" flattens.

We believe we are on the cusp of such a moment in public education, as the argument for abstinence only until marriage is beginning to assert a kind of natural cultural authority, in schools and out. The fizz of dialogue is being censored in many classrooms and beyond, with serious educational and health consequence for young women — for some more than others, but indeed for us all.

## Thick Desire

This article picks up where we left off in 1988. Almost twenty years later, for better or worse, the discourse of adolescent desire is no longer missing (Harris, 2005). It has been splashed all over MTV, thoroughly commodified by the market, and repetitively performed in popular culture. A caricature of desire itself is now displayed loudly, as it remains simultaneously silent (Burns & Torre, 2005; Harris, 2005; Tolman, 1994, 2002, 2006). A telling piece of evidence that demonstrates how fully young women have taken on the performance of desire is the startling statistic that the number of teens having breast implants nearly quadrupled from 2,872 in 2002 to 11,326 in 2003 (Albert et al., 2005).

Today we can “google” for information about the average young woman’s age of “sexual debut,” if she used a condom, got pregnant, the number of partners she had, if she aborted or gave birth, and what the baby weighed. However, we don’t know if she enjoyed it, wanted it, or if she was violently coerced. Little has actually been heard from young women who desire pleasure, an education, freedom from violence, a future, intimacy, an abortion, safe and affordable child care for their babies, or health care for their mothers. There is almost nothing heard from the young women who are most often tossed aside by state, family, church, and school — those who are lesbian, gay, bisexual, queer, or questioning (LGBTQQ),<sup>2</sup> immigrant and undocumented youth, and young women with disabilities. While these marginalized young people may yearn for quality education, health care, economic well being, and healthy sexual lives, day to day they attend under-funded schools, contend with high-stakes testing, endure heightened police surveillance, are seduced by military recruitment promises, and are surrounded by fundamentalist ideologies working to reconstitute their public school classrooms and penetrate courts and state legislatures (Fine, Burns, Payne, & Torre, 2004).

The past two decades have seen a radical growth curve of neo-liberal reform. Throughout this period, the very public policies and institutions designed to facilitate the healthy development of young people — particularly Black, Latino, and Native American youth, those living in poverty, and/or recently immigrated to the United States — have been severely compromised.

Thus, as a friendly amendment to the 1988 essay — and with the wisdom of hindsight and living in a different global politic — we offer educators and researchers a historic revision to the missing discourse of desire. We offer instead a framework of *thick desire*, arguing that young people are entitled to a broad range of desires for meaningful intellectual, political, and social engagement, the possibility of financial independence, sexual and reproductive freedom, protection from racialized and sexualized violence, and a way to imagine living in the future tense (Appadurai, 2001, 2004; Nussbaum, 2003). We understand that young women’s thick desires require a set of publicly funded enabling conditions, in which teen women have opportunities to: (a) develop intellectually, emotionally, economically, and culturally; (b) imagine

themselves as sexual beings capable of pleasure and cautious about danger without carrying the undue burden of social, medical, and reproductive consequences; (c) have access to information and health-care resources; (d) be protected from structural and intimate violence and abuse; and (e) rely on a public safety net of resources to support youth, families, and community.

A framework of thick desire situates sexual well being within structural contexts that enable economic, educational, social, and psychological health. In this essay, we seek to understand how laws, public policies, and institutions today both nourish and threaten young women's sense of economic, social, and sexual possibility (Appadurai, 2004; Nussbaum, 2003).

In the remainder of this article, we examine various public contexts in which thick desire grows or is extinguished — public education, juvenile justice, and sexuality policies. In these contexts, we illuminate specific embodied intersections where young women live, varied by race, ethnicity, class, disability, sexuality, family arrangements, and even geography (Crenshaw, 1995). By examining the changes in sex education policy over the past two decades, and the effects on distinct groups of young women, we can see that enabling conditions for thick desire ossify as *public assistance* and are replaced with *punishing morality* as neo-liberalism and fundamentalism frame public educational policy.

### Developmental Contexts for Thick Desire: Public Institutions and “Private” Choices

Neo-liberalism marks the government's shift to the Right, whereby public responsibility for social well being has been evacuated by the state and replaced with private resources, or more often, not replaced at all. Personal needs have been exiled from the public sphere, sent out to the marketplace or back into the family (Luker, 2006). At the same time that the state walks away, it leaves behind a moralizing ideology about bad “personal choices” enacted by those who transgress (see Fine & McClelland, in press, for a discussion of moralizing discourses regarding reproductive freedoms). During the past twenty years, the social contract with poor and working-class Americans has been severed. The wealth gap between elites and the poor has swelled (Reich, 2002). College tuition rates have risen while financial aid in the form of need-based scholarship has declined (Burd, 2006, p. 3). During this era, quality and insured health care, even for the middle class, has moved increasingly out of reach (Starr, 2004). Many teens have made seemingly bad “choices” in this era.

Young women's bodies and desires take intimate shape in responding to and contesting public policy shifts (Brown, 2003; Srinivasan, 2004). In order to document the tangled enmeshment of public policy and adolescent female sexuality, we select two public policies which severely disable young people's material and social resources. The proliferation of high-stakes testing and juvenile incarceration remind us how personal choices and outcomes are not

"natural," nor are they entirely personal. While differential educational, criminal justice, and reproductive outcomes by race and class are typically cast as (ir)responsible private choices, we bind these outcomes to deliberate public policy decisions (Geronimus, 1997).

### *Unequal Schooling Opportunities*

A number of public policies, including fiscal inequity, unequal distribution of certified educators, high-stakes testing, retreat from bilingual education, and affirmative action, have colluded to produce a grossly uneven landscape of public education; what Jonathan Kozol has called the "shame of the nation" (2005). To take just one policy and unravel its consequences, let's consider the well-documented relationship of high-stakes exit examinations and the associated rise in Black and Latino dropout rates. Here we bear witness to the harsh consequences of a public policy seemingly remote from sexual and reproductive outcomes (Anyon, 2005; Sullivan et al., 2005).

Policymakers claim that the implementation of high-stakes exit exams leads to improved performance and increased achievement. Yet cross-state studies reveal that as these tests are implemented, dropout/push out rates of English-language learners and minority students rise and the achievement gap widens (see Allensworth, 2004; Haney, 2000; McNeil, 2005; Sullivan et al., 2005; Valenzuela, 2004). Amrein and Berliner (2002) map the geography of high-stakes exit examinations and find that African American, Latino, English-language learners, and immigrant students are disproportionately required to pass high-stakes tests in order to graduate from high school and disproportionately fail. The widespread reliance on high-stakes exit exams has unleashed an increase in what is now called "diploma penalty," denying more and more youth their diplomas (Haney, 2000; Orfield, Losen, Wald, & Swanson, 2004).

Students who drop out/are pushed out of high school earn less, are more likely to be sick, have higher mortality rates, are more likely to be incarcerated, be on public assistance, get pregnant, bear a second child, and/or give birth to a low-birth-weight infant than those who graduate (Fine, 1991; Luttrell, 2002; Freudenberg & Ruglis, 2006; Reichman, 2005). In fact, 38 percent of teen women who left school prior to graduation had a subsequent pregnancy and birth while still a teen, compared to 11 percent of young women who did not (Kaufman, Alt, & Chapman, 2004; Manlove, 1998). This pattern is even more dramatic for young women with disabilities. The National Longitudinal Transition Study (2005) reported that learning disabled students who drop out of high school are five times more likely to bear a child within two years than those who graduate (p. 5). The correlation of drop out and teen pregnancy is particularly high for young women with mental retardation. Academic failure and leaving school prior to graduation are strong predictors of early pregnancy (Rousso, 2001).

Across diverse groups of teens, every year of education has economic, health, and reproductive benefits. Young adults who graduate from college are far more likely to vote and pay taxes, and are three times less likely to have an “unintended” pregnancy than those who drop out of high school (Finer & Henshaw, 2006). High dropout rates are costly for individuals, families, communities, and the fabric of our nation; they are most deeply etched into the backs of students attending under-funded schools, living in poverty, and facing racism. While 70 percent of all U.S. students graduate from high school with a regular diploma, this is true for only 51.6 percent of Blacks, 55.6 percent of Latinos, and 47.4 percent of Native Americans (“Diplomas count,” 2006). This single policy move of high stakes testing, enacted presumably in an effort to leave no child behind, bears significant economic, criminal justice, and reproductive consequences (see Lipman, 2005; Orfield et al., 2004).

### *Unequal Placement in Juvenile Detention Facilities*

In the very same communities where drop out rates are rising we see another public policy avalanche: the aggressive criminalization and incarceration of juveniles. Within a political economy hostile to non-college graduates, these two policy initiatives tragically short circuit the developmental possibilities for poor and working class youth of color (Richie, 1996; U.S. Department of Justice, 1999, p. 2).

The 1999 Census of Juveniles in Corrections showed a 43 percent increase in youth involved with the criminal justice system since 1991 (Sickmund, 2004, p. 4). This increase is accounted for by young people who are disproportionately minority, under-educated, and female. While Black juveniles constitute 15 percent of the U.S. population aged ten to seventeen, they account for 45 percent of delinquency cases involving detention, 40 percent of those placed in residential placement, and 46 percent of cases judicially waived to criminal court (Hsia, Bridges, & McHale, 2004). From 60 to 80 percent of juveniles and young adults in prison have neither a high school diploma nor a G.E.D. (see Fine et al., 2001).

Analyzing these data over time reveals a significant rise in arrest rates for teen women. From 1980 to 2002, female juveniles arrested for aggravated assault rose by 99 percent (compared to a 14 percent increase for boys); 258 percent for simple assault (compared to a 99 percent increase for boys); 125 percent for a weapons charge (compared to a 7 percent increase for boys); and 42 percent for drug offenses (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2004; Sickmund, 2004). Once in the system, racial disparities within gender accumulate: a full 70 percent of cases involving White girls but only 30 percent involving Black girls are dismissed (Poe-Yamagata & Jones, 2000), with Black girls far more likely to be waived into adult facilities (Bloom, Park, & Covington, 2001; Schoen et al., 1997). Girls constitute



60 percent of those teens arrested as runaways. They are far more likely than boys to be subsequently placed in care or detained for minor offenses, public disturbances, truancy, and status offences; almost three times as likely to be detained for parole and probation violations, and yet far less likely to recidivate based on a new crime (Miller & White, 2004; Schaffner, 2002, 2004).

Since the 1980s, criminal detention for young women has come to represent our national response to racialized and classed educational inequities (Kozol, 2005), family abuse, adolescent mental health, and drug problems (Richie, 1996, 2000, 2001). Just over 61 percent of young women in juvenile facilities report having a history of physical abuse, and 54.3 percent have experienced sexual abuse (American Correctional Association, 1990; see also, Brown, Miller, & Maguin, 1999; Brown & Taverner, 2001; Chesney-Lind & Okamoto, 2001; Simkins, Hirsch, & Horvat, 2003; Simkins & Katz, 2002). As a form of social control on girls, and disproportionately on Black and Latino girls, juvenile detention fails to remedy the original problems and serves instead to criminalize and diminish the educational, economic, and health outcomes of young women.

Roberts (1997) has documented a long history of reproductive racism, juxtaposing the innocence of White childhood with the guilt of Black childhood. "The powerful Western images of childhood innocence do not seem to benefit Black children. Black children are born guilty. The new bio-underclass constitutes nothing but a menace to society — criminals, crack heads, and welfare cheats waiting to happen" (p. 21). Roberts argues that presumptions of guilt linger in the bodies of poor youth of color. For evidence of this sentiment, we need look no further than former Secretary of Education William Bennett (1993), author of *The Book of Virtues*, who commented recently on the radio:

If you wanted to reduce crime . . . if that were your sole purpose, you could abort every Black baby in this country and your crime rate would go down. This would be an impossible, ridiculous and morally reprehensible thing to do . . . but the crime rate would go down (CNN, 2005).

Symbolic violence (Bourdieu & Passeron, 1977) combines with structural and intimate violence to escort young Black (and Latina, Native, poor, and working class) women out of their schools and homes, toward the streets, and into juvenile facilities. The absence of educational, health, sexual, and reproductive resources before they enter (and once they are in) these facilities only makes it more likely that they will return, next time perhaps infected with a sexually transmitted disease, perhaps with a baby who will, in all likelihood, have to be put in foster care.

Adolescent sexual well-being sits within a broad politic of homeland insecurity: high-stakes testing, aggressive incarceration of youth of color, and the evaporation of medical benefits for millions (Starr, 2004). Private acts are never wholly private; intimate choices are always profoundly social. In the

midst of these parallel public policies, the press for abstinence-only education reveals just how far, and for whom, social policies can harm and then punish private lives. In this contentious political context, the campaign for abstinence in schools and communities may seem trivial, an ideological nuisance, but at its core it is a further violation of human rights and a betrayal of our next generation, which is desperately in need of knowledge, conversation, and resources to negotiate the delicious and treacherous terrain of sexuality in the twenty-first century.

## Abstinence Only Until Marriage

### *A Brief History*

Understanding the policy contexts in which young women try to carve out meaningful lives, we turn now to a brief history of the abstinence only until marriage (AOUM) movement to expose yet another layer of public life with which young people must contend as they stitch together sexual lives.

The 1981 passage of the Adolescent Family Life Act marked the first federal law expressly funding sex education “to promote self-discipline and other prudent approaches” (Adolescent Family Life Act, 42 U.S.C. § 300z [1982 & Supp. III 1985], as cited in Kelly, 2005). In 1996, with the Congressional passage of the Personal Responsibility and Work Opportunity Reconciliation Act, AOUM education funds gained an additional funding source through the approval of Title V of the Social Security Act. Under Title V, the U.S. Department of Health and Human Services (DHHS) allocates \$50 million annually in federal funds to the states. Since 1982, when funding was first earmarked for AOUM education, over one billion dollars has been spent through federally sponsored programs (including AFLA, Title V, and CBAE; *Sexuality Information and Education Council of the U.S. [SIECUS]*, 2004c). For the 2007 budget, President Bush advocated for and was granted \$204 million in AOUM funding and, according to the U.S. Office of Management and Budget (2006), the federal budget “supports increasing funding for abstinence-only education programs to \$270 million by 2009.”

Virtually all of the growth in funding since 2001 has come from the Community Based Abstinence Education (CBAE) program (Santelli et al., 2006a; SIECUS, 2004c). CBAE funding is typically granted to community and local organizations, but states are eligible to apply, and many states use this funding stream to bolster their existing AOUM school programming that rely on federal Title V monies (SIECUS, 2004a). Programs funded under CBAE are explicitly restricted from providing young people information about contraception or safer-sex practices — this includes organizations that might use nonfederal funds to do so (Santelli et al., 2006a; see SIECUS, 2004a, for description of federal AOUM funding streams). In early 2006, the U.S. DHHS issued a request for proposals, anticipating spending \$24 million on approximately fifty programs at an average of \$425,000 for five years (U.S. Depart-

ment of Health and Human Services [U.S. DHHS], 2006). Faith-based organizations were encouraged to apply.

All federally funded abstinence programming must adhere to the following series of principles, called "A to H." According to Section 510(b) of Title V of the Social Security Act (U.S. DHHS, 2003, p. 14), the term "abstinence education" means an educational or motivational program that

- a. has the exclusive purpose of teaching the social, psychological, and health gains to be realized by abstaining from sexuality activity;
- b. teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;
- c. teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- d. teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity;
- e. teaches that sexual activity outside marriage is likely to have harmful psychological and physical effects;
- f. teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
- g. teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances;
- h. teaches the importance of attaining self-sufficiency before engaging in sexual activity.

The eight central tenets of AOUM education impose a strict set of criteria on educators who are looking to educate young people about their sexuality. The "A to H" points are designed to discourage teenage sexual behavior and, ultimately, to reduce rates of teenage pregnancy and sexually transmitted diseases. At the same time, however, they also introduce ideological intrusions that are not merely about reducing sexual behavior, but also instruct young people to adopt very specific normative relationships to their sexuality. There is, notably, the "expected standard" that sexual activity occurs only within the context of marriage, a move that places not only teenage sexual behavior but the sexual choices made by people of all ages and all sexual orientations outside the limits of appropriate behavior. Furthermore, the eight central tenets of AOUM suggest a direct and (im)moral route from nonmarital sex to disease and social problems. Insisting that young people be instructed that "sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects" and that "bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society" does not lodge sexuality education in a foundation of information and support for a healthy adult sexuality. Instead, it lodges sexuality education in fear and shame, firmly burying discussions of desire and pleasure.

The promise of federal dollars often pushes the schools and communities in impoverished areas into accepting these curricular restrictions in order to fill funding gaps. Students who are most in need of education and health care — poor urban and rural students — are thereby the most likely to be mis-educated through these curricula (see SIECUS, 2004a for state-level data on the distribution of AOUM funds). The distribution of AOUM curricula favors communities with high levels of teen sexual activity and teen pregnancy and, importantly, imposes religious and moralizing curricula more strongly on youth who have already been sexual and who most need information about how to avoid pregnancy and sexually transmitted diseases. These are the very communities already plagued by increased drop out/push out rates and juvenile incarceration. For example, in 2006, Massachusetts governor Mitt Romney's administration shifted federal AOUM funding from an emphasis on media campaigns to classroom programming that was specifically aimed at students ages twelve to fourteen in schools in Black and Hispanic communities throughout the state (Helman, 2005). This example reflects the trend toward State-sponsored distribution of religious fundamentalism in communities where state policies threaten educational and health outcomes for youth.

### *Marriage Legislation and Promotion*

In addition to the federal monies devoted to AOUM programming, other relevant policy shifts have focused state energies and funding on encouraging men and women to marry if they have a child together. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act established a financial incentive to reduce out-of-wedlock childbearing. It authorized \$100 million in annual bonus payments to the five states that achieved the largest reduction in out-of-wedlock births among welfare and non-welfare teens and adults and reduced abortion rates among that population to less than the 1995 level in their state. In 2000, four new measures were created for the High-Performance Bonus, including a measure of family formation and stability. The marriage bonus is awarded to a state that can demonstrate an increase in the percent of children who reside in married couple families (Ooms, 2001).

According to the U.S. Department of Health and Human Services (2003), federal funding is meant to enable states to "focus on those groups most likely to bear children out-of-wedlock" (p. 14). Federal policies that promote marriage through interventions like the Personal Responsibility Act punish poor single mothers for not choosing to marry. This type of monetary and institutional enforcement of marriage negates their right to form intimate associations on their own terms (Mink, 2002; see also Levin-Epstein, 2005, for a discussion of marriage promotion policies). By targeting communities with high rates of children born outside marriage, federal marriage policies not only dictate who receives funding, but also place blame for societal woes on

those individuals who are most denied enabling conditions for thick desire (see Karney, 2006, for discussion of attitudes about premarital sex among various groups).

*What Is Taught in Schools: The Chill*

To give some sense of how federal policies move into classrooms, it is useful to note for example, that New York State received \$9,346,650 in federal funding for AOUM programs in 2004 (SIECUS, 2004a). While this is just one state, it exemplifies the national trend at both the federal and state levels to allocate funds for exclusively teaching abstinence-only to young people. It is estimated that 33 percent of all public schools now offer AOUM curricula (Planned Parenthood, 2005a). Since 1988, the number of sex education teachers who teach AOUM has grown tenfold, from 2 percent to 23 percent (Santelli et al., 2006a). As abstinence funding and education spread across the nation, the net of teen activities considered in violation of abstinence regulations stretches as well. In 2006, the federal guidelines for funding AOUM education underwent substantial revisions (see U.S. DHHS, 2006). The new guidelines explicitly endorse the U.S. government's support of abstinence. However, instead of encouraging adolescents to avoid sexual intercourse, the new definition casts a much wider net of proscribed activity: "Sexual activity refers to any type of genital contact or sexual stimulation between two persons including, but not limited to sexual intercourse" (pg. 5). Apparently in responding to criticism that abstinence previously had not been adequately defined (Santelli, Ott, Lyon, Rogers, & Summers, 2006b), this updated version creeps into the territory of all things "stimulating." This broad definition of abstinence removes any possibility for sex education curricula to mention how teens might engage in non-intercourse behaviors, even in an effort to remain "technically" abstinent.

These guidelines set up an impenetrable wall between youth and adults, reducing the likelihood that conversations will occur between young people and educators, health-care practitioners, and youth workers. The loss of these conversations puts young people's health at risk (see Fine & McClelland, in press, for discussion of how a lack of supportive adults affects adolescent reproductive freedoms). Again, we can see that the costs of constricted talk are quite severe for some groups of youth. Consider, for instance, Harilyn Rousso's (2001) finding that young women with physical and sensory disabilities are far less likely than their nondisabled peers to receive any kind of sexuality education and are far less likely to talk to their mothers, friends, or teachers about sexuality and reproduction. Combine this with the finding that disabled youth are almost twice as likely to report sexual abuse as are nondisabled children, with estimates that 39 percent to 68 percent of disabled girls and 16 percent to 30 percent of disabled boys are sexually abused before the age of eighteen (Rousso, 2001). Looking at the cumulative effect of parents who are particularly overprotective of young women with disabilities and spe-

cial education programs that are typically under-equipped to take up sexuality education, we see that

the consequences of inadequate sex education may be more severe for students with disabilities who have less access to informal sources of sex education such as peers, casual observation, written materials, and the media. (p. 38)

With disproportionate histories of abuse and little in the way of home or peer guidance around sexuality, students with disabilities make clear the need for more information although they receive less.

The 2006 federal guidelines regarding AOUM education funding cut off any discussion of how teenagers might develop healthy sexual behaviors for present or future relations. In the name of protection, the teenage sexual body has been sent underground with little information and almost no protection.

### A Closer Look at the AOUM Content

In 2004, a systematic review of the abstinence-only curricula was commissioned by U.S. Representative Henry A. Waxman, ranking minority member of the Committee on Government Reform (2004), to evaluate the scientific and medical accuracy of thirteen of the most commonly used of these curricula. Reviewers found that two-thirds of the programs contained basic scientific errors (e.g., warnings that sweat and tears are risk factors for HIV transmission; see p. 219); relied on curricula that distorted information about the effectiveness of contraceptives (e.g., claims that condoms fail approximately 31 percent of the time; see p. 91); blurred religion and science (e.g., presenting as fact that life begins with conception; see p. 23); and reinforced stereotypes about girls and boys as scientific facts (see Brown, 2005).

Many curricula for AOUM programs link nonmarital sex with disease and possible death (see Kempner, 2001, for further discussion). Researchers have noted that these curricula often include scare tactics such as the video titled *No Second Chance*, in which a student asks a school nurse, "What if I want to have sex before I get married?" to which the nurse replies, "Well, I guess you'll just have to be prepared to die" (as cited in Levine, 2002). The national AOUM program Family Accountability Communicating Teen Sexuality (FACTS) instructs students that "there is no such thing as 'safe' or 'safer' premarital sex. There are always risks associated with it, even dangerous, life-threatening ones" (Fuller, McLaughlin, & Asato, 2000, as cited in Kempner, 2001, p. 19). Young people are being instructed continually to believe sexual activity is dangerous to their health.

### *The Press for Heterosexual Marriage*

In the AOUM curriculum, not only is teen sexuality always bad, but heterosexual marriage is always good. In fact, marriage is presented as the only

context for safe sex. The pro-marriage language of the AOUM curricula was strengthened in 2005, when programs once designed to discourage “*premature sexual activity*” and to encourage “*abstinence*” were redesigned to discourage “*premarital sexuality activity*” and encourage “*abstinence only until marriage*” decisions (Dailard, 2005). The framework for AOUM funding demanded that abstinence curricula define marriage as “a legal union between one man and one woman as a husband and wife, and the word ‘spouse’ refers only to a person of the opposite sex” (U.S. DHHS, 2006). In addition, funding restrictions required that having sex within marriage be presented as the only way for teens to avoid getting STDs and related health problems. Heterosexual marriage was presented as the answer to safe sex even as same-sex marriage was fought by many of these same abstinence advocates.

In this push for heterosexual marriage, we see a telling instance where the chance to educate teens about the potential dangers inherent in early (and any) marriage gets lost. The little research that exists on teen marriage has found that young marriages often have high levels of violence. Young mothers who marry are more likely to have a second child shortly after the first than those who do not, and teenage women who marry and then divorce have worse economic outcomes than teenage mothers who never marry (Seiler, 2002). Teen marriage significantly reduces the likelihood that a woman, especially a young mother, will return to school. A study of African American teenage mothers found that 56.4 percent returned to school within six months of having a baby if they did not marry, compared to 14.9 percent of those who did marry (Seiler, 2002). In AOUM instruction, these problems of heterosexual marriage are sidelined, the risks of contracting sexually transmitted diseases, including HIV within marriage, are ignored, and the issue of same-sex marriage is silenced.

### *Homophobic Violence and Harassment*

For lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) youth, the AOUM curriculum not only fails to address their very real educational needs and concerns, but, more significantly, it colludes in the homophobic harassment already present in public school settings. More than one-third of LGBTQQ students report hearing homophobic remarks from teachers or school staff, and nearly 40 percent indicated that no one intervened when homophobic comments were made (Brown & Taverner, 2001). While this kind of harassment certainly preceded the introduction of AOUM curriculum (and AOUM doesn’t cause this kind of harassment), the curriculum fails to challenge the heterosexual normativity in schools. Because the abstinence model is predicated on waiting until marriage for sexual expression, and marriage is not an option for these youth, the AOUM curricula not only denies LGBTQQ youth legitimacy, but it also asks them to hold aside (and silence) significant pieces of their identities in order to participate in

the *moral* community of students (Opotow, 1990) who deserve sexuality education. This is particularly true when the conversation turns to misinformation about same sex practices, the presumed failures of condoms, and the much repeated claim that sex inside marriage is the only form of healthy sexuality.

### A Question of Accountability: Educational and Health Consequences

Given the fact that the aim of AOUM policies is to protect the health of young people, one would assume that this instruction would be joined by an ambitious evaluation of the health and sexual outcomes of those youth who are exposed to AOUM curricula. This has not been the case. Instead, concern for adolescent health has been set aside and replaced with a simple evaluation focus on whether or not students endorse beliefs about abstinence and marriage. This can be seen in the guidelines produced by the U.S. DHHS. In 2005, programs that received federal AOUM funding were required to include demonstrable outcomes, such as a reduction in STDs and pregnancies among adolescents (U.S. DHHS, 2005). By 2006, the U.S. DHHS stepped away from using behavioral and health outcomes as a way of judging a program's success and replaced these with the requirement that programs demonstrate that they "create an environment within communities that supports teen decisions to postpone sexual activity until marriage" (U.S. DHHS, 2006). This shift is important as it marks a distinct lack of accountability for education and health behaviors on the part of AOUM programs (see McClelland & Fine, *in press*, for further discussion of the evaluation of AOUM programs).

That these programs are no longer required to improve young people's health in order to be considered successful is worrisome in light of empirical data about how abstinence education actually affects adolescent (and later, adult) sexual health. These include how long youth remain abstinent, what choices they make when they decide to have sex (including sexual behaviors and contraception use), and the long-term consequences of learning exclusively about the dangers of sexuality.

One way to measure the question of what choices young people make when they decide to engage in sexual activity is to measure STD rates after young people take "virginity pledges," an exercise that exists within some AOUM programming. Bearman and Brückner (2001) found that "pledgers" typically delayed their first heterosexual intercourse an average of eighteen months later than nonpledgers. In a follow up, however, Brückner and Bearman (2005) found that 88 percent of the middle and high school students who had sworn to abstain did, in fact, have premarital sex — and, importantly, often had unprotected sex. Pledgers were 30 percent less likely than nonpledgers to use contraception once they became sexually active, and also less likely to use condoms and seek medical testing and treatment.



Other adolescent health researchers have studied the “user-failure” rates for abstinence; in other words, the numbers of youth who promise to be abstinent until marriage, but in fact do have premarital sex. By studying teens that abstained for a period of time, Haignere and her colleagues (Haignere, Gold, & McDanel, 1999) found that abstinence education had a user-failure rate between 26 percent and 86 percent. This rate is higher than the condom user-failure rate, which is between 12 percent and 70 percent. These findings highlight the temporary quality of virginity pledges and the nonsustainability of intentions to abstain. This finding would not be cause for alarm, except for the fact that these youth who have been instructed using AOUM curricula and who have pledged to remain abstinent are becoming sexually active with no information about how to do so successfully and safely.

These young people are being educated to mistrust condoms and contraception, to feel shame about their premarital sexuality, and to remain silent about their own sexual development. By insisting that a pledge of abstinence is enough to guarantee subsequent sexual decision-making — by condemning premarital sexual activity, contraception, and condoms — educators, policymakers, and families are placing young people at risk. Even adults who want young people to remain abstinent until marriage recognize that it is unlikely they will do so. For example, in a recent national poll, of those parents who stated that they thought girls should wait until they are married to have sexual intercourse, 89 percent said they thought that most girls will have intercourse earlier [than that] (National Public Radio et al., 2004, p. 19).

Research has repeatedly shown that students in comprehensive sexuality education classes — those that teach various strategies to reduce pregnancy and disease, and to pursue healthy sexual development — do not engage in sexual activity more often or earlier than those in AOUM classes; they do, however, use contraception and practice safer sex more consistently when they become sexually active (Kirby, 1997, 1999, 2000, 2001). Kirby (1997) found that “the weight of the evidence indicates that these abstinence programs do not delay the onset of intercourse” (p. 25). Kirby also found evidence that programs that address both abstinence and contraception resulted in better sexual health outcomes for young people.

As a significant adjunct to comprehensive sexuality education, there has been an important school-based health center (SBHC) movement underway since the 1970s that has positively affected adolescent health outcomes. From 1988 to 2001, the number of SBHCs has grown from 120 to almost 1,400 in forty-five states. SBHCs aim to provide comprehensive, accessible, and quality health services in culturally sensitive contexts for youth lacking insurance and/or access to medical care. Reduction in the misuse of emergency rooms and an increase in medical and mental health services have been well documented (Schlitt et al., 2000). A quasi-experimental evaluation of condom distribution programs found that school-based access to condoms does not

increase rates of sexual activity, but does heighten the use of condoms by students who are sexually active (Guttmacher et al., 1997). Moving educational and health resources to schools does not appear to increase sexual activity, but does contribute to a sense of sexual responsibility.

It is clear that sexuality education must serve all youth with information, support, and resources that allow young people to make informed decisions about their bodies and their sexual health. As you will see from what follows, young people desperately need and deserve far more information, sustained and safe conversations with peers and adults, and more sophisticated critical skills to negotiate the pleasures and dangers of their quite active — and often uninformed — sexual lives.

### Sex in Numbers

We turn now to the epidemiological data on teen sexuality, trying to understand how sexual and reproductive health outcomes distribute across youth. But first, a warning about how to read sexuality statistics. The statistics that follow tell us something about what young women are doing with their bodies, but they do not tell us about sexual subjectivities (Horne & Zimmer-Gembeck, 2006) — that is, if these activities were wanted or enjoyed by these young women. When we see high rates of STDs and pregnancy among teenage girls, *whom* do we imagine (Wyatt, 1994)? Do we imagine a girl we consider a desirous subject, a victim, or both? And what of her access to a quality high school, college, health insurance, a place to call home? Have we learned whether her school district was adequately financed with certified educators? Was she able to attend a high school that offered her a sense of cultural belonging, a chance to enquire, a strong curriculum of advanced mathematics, science, writing, and informed college counseling? Has her community received more resources devoted to policing and criminal justice than education, more military recruiters than sexuality educators? Was she taught about masturbation, LGBTQQ sexualities, abortion, pleasures, and dangers? Could she confide in anyone about her stepfather, uncle, disability-related caretaker, or mother abusing her? How many sick or dependent relatives was she caring for because the state didn't?

In the end, what do statistics on sexual behaviors tell us about the presence, absence, or subversion of enabling conditions for thick desire? More importantly, what do they obscure about a girl's access to health-care, insurance, the quality of her school, or the wide variation of sexual histories within her racial group? As we turn now to the seductive details of teen sexuality — rates, types, and consequences — we hope that the reader will ingest these numbers critically, always imagining real young women developing real bodies at vibrant intersections, affected by distant international and federal policies, local institutions, communities, complex intimate relations, and itchy, unformed, and still developing desires for a better tomorrow.

*Teen Heterosexual Sex and Pregnancy*

The Centers for Disease Control and Prevention (CDC) report that more than one-third of fifteen to seventeen year-old males (36 percent) and females (39 percent) have had vaginal intercourse; almost one-third have given oral sex (28 percent of males and 30 percent of females); and more have received oral sex (40 percent of males and 38 percent of females). Adolescent females are about twice as likely to report same-sex sexual contact as males (Mosher, Chandra, and Jones, 2005, p. 9).

International comparisons are critical because they allow us to consider what these numbers reveal about adolescent life in the U.S. Teens in the U.S., on average, begin having heterosexual intercourse at 17.4 years of age; the average age is 18 in France, 17.4 in Germany, and 17.7 in the Netherlands (Feijoo, 2001). Yet young women in the United States are *nine* times more likely to become pregnant than young women in the Netherlands. The U.S. teen pregnancy rate is almost twice that of Great Britain, four times that of France and Germany, and more than ten times that of Japan. National context matters — intimately.

Despite these international comparisons, by 2000, U.S. teen pregnancy rates had dropped to an all-time low for White, Black, and Latina women (CDC, 2005; National Campaign to Prevent Teen Pregnancy, 2005). Teen birth rates also dipped from 89.1 for every 1,000 young women in 1960 to 41.7 in 2003; 18.3 teen births per 1,000 for Asian Americans; 28.5 for Whites; 68.3 for African Americans and 83.4 for Latinas (Kaiser Family Foundation, 2004). Santelli and colleagues (2004) have suggested that the recent decline in pregnancy rates can be attributed to a combination of decreased sexual experience and increased use of contraception.

*Condoms, Contraception, and Abortions*

Using our 1988 benchmark to track progress, we can see that young women's risk of pregnancy has declined by 21 percent from 1991 to 2003, largely because of improvements in contraceptive use among White and Black teens. In 1991, in a sample of surveyed high school girls, 22 percent used the pill only and 35 percent condoms only. By 2003, 14 percent used the pill and 49.3 percent used condoms (Santelli, Morrow, Anderson, & Lindberg, 2006c).

What looks like good "individual" news seems a bit more complex "relationally" in our ethnographic conversations with diverse groups of high school students in the New York metropolitan area, where we got an earful about the gendered politics of negotiating condom use:

*Michelle:* So, for those young people who do engage in sex, do they use condoms?

*Young men:* Sometimes, yeah, not always.

*John:* Really, I like it raw.

*Michelle:* Do you worry about pregnancy or disease, HIV?

*Kevin:* Yeah, we got SuperAids in this town.

*Lawrence:* Nah... Magic Johnson's OK — if you got money you don't get AIDS, they got medicines, but for the rest of us, it will kill you in three weeks.

*Michelle:* Can young women carry condoms and pull them out as needed?

*Marcos:* No way, I wouldn't trust the girls to do that. They would stick pin holes in the condoms.

*Two young women:* (*appearing shocked*) Why would we do that?

*Steve:* To get the baby, then you think he'll stick around.

*Michelle* (*after viewing a bag that the teacher displayed of more than twelve forms of contraception, all to be used by/inserted into young women*): So what if there were a pill for young men. You can have an erection, ejaculation, just no sperm. Would you use it?

(*Half of the students say "yes" while the other half give other responses.*)

*Young men:* No way, I'm not putting anything into my body. Could kill you. Could make you sterile.

(*Two young women roll their eyes.*)

In this conversation we heard young men who were worried about HIV/AIDS but who still preferred to have sex "raw." In another setting, we heard that many "guys where I live" considered "protection is for soft n—gers." We heard young men and women agree that with access to enough money, a person could avoid dying from AIDS, like Magic Johnson, but those without money were likely to die within three weeks. In another school, the young men worried aloud that their partners may not be clean: "I make sure she carries Baby Wipes and uses them before we get involved." Young men were clear that they didn't want to insert chemicals or barriers into their bodies, as young women rolled their eyes and detailed the labors, risks, and burdens of assuming sole responsibility for protection.

Across our conversations with youth, however, young men and women agreed that conversations like these were desperately needed in order to dispel the myths and layers of misinformation that are already part of how young people learn about sex. Referring to the 2003 opinion issued by the Kansas attorney general (see Kline & Nohe, 2003), we asked, "What would happen if adults — teachers, nurses, counselors — had to report to the State, any sexual activity by anyone sixteen or younger?" After the gasps, one young woman gathered up the courage to whisper, "I couldn't live in a world like that. Who could I talk to? I would have no one." The critical role of caring and supportive adults, for conversation and information, was repeated across schools, across gender, across race, ethnic, and class lines.

In one of the schools, our conversation turned to the question of abortion. The discomfort in the room was palpable; we could feel the strong resistance to acknowledging abortions in this low-income, predominantly African American and immigrant community.

*Michelle:* So, do people in this school talk about how you can get an abortion if you need or want one?

*Teacher:* Not so much in this community. They don't really get abortions here.

*Students:* We don't talk about it that much.

Most of the young people (and their educators) knew much about the pregnancies and births in their community, but not about the abortions. We sent them the local statistics to contradict the shared sense that "they don't really get abortions here." When we look at the rates at which young women are terminating their pregnancies (Table 1), it is clear that there is a silent yet highly regular process that young women are engaging in — privately, maybe with a friend or relative, perhaps with shame, perhaps with a sense of relief, but likely imagining themselves to be the only young women in their community having an abortion. Table 1 summarizes the data on teen women's pregnancies, births, and abortions. The statistics come from the Guttmacher Institute, one of the most reliable resources for health indicators for young women.

Table 1 also displays the differential rates by which White, African American, and Latina teens experience pregnancy and abortions. For example, Latinas get pregnant close to three times the rate of White girls, and African Americans at rates more than three times those of Whites. Table 2 is more nuanced in terms of use of birth control. It shows that while all three groups rely on condoms more than other methods, White girls are the group most likely to use the pill (which requires access to a health-care provider, a prescription, and some way to pay for contraception), African Americans are more likely to use condoms, and Latinas are more likely to rely on withdrawal or no method at all.

Simply put, the consequences of unequal knowledge about, access to, and use of affordable contraception, health care, and education are unevenly distributed by race, ethnicity, and class. While these data are too often framed as good or bad, moral or immoral, reproductive choices or cultural differences, we highlight the fact that choices are never made independent of history and politics, both outside and within communities. Laws concerning young women are some of the most powerful (and relatively unseen) structural factors that exist. Looking at these data that enumerate the consequences of sexual activity, it is clear that young women of different ethnicities in the same nation, state, or even community may be living within very different social, political, and economic structures; it is not simply a matter of their making indi-

**TABLE 1** *U.S. Teen Pregnancies, Births, and Abortions Per Thousand Women Ages Fifteen to Seventeen*

	<i>Pregnancies</i>	<i>Births</i>	<i>Abortions</i>
White	31.0	19.4	11.6
African-American	103.2	62.6	40.6
Latina	88.2	66.3	21.9

*Source:* Frost, Jones, Woog, Singh, & Darroch (2001, p. 7)

**TABLE 2** *Percent of Birth Control Methods by Race, Sexually Active Women Ages Fifteen to Seventeen*

	<i>Pill</i>	<i>Condoms</i>	<i>Withdrawal</i>	<i>No Method</i>
White	18.9	44.0	11.5	12.3
African-American	5.6	57.3	10.6	12.1
Latina	4.9	45.2	16.3	19.8

*Source:* Santelli et al. (2004)

vidual choices about their sexuality. The gendered, raced, and classed burden of teen sexuality is neither natural nor merely a question of biological destiny or culture. A full 82 percent of pregnant teens ages fifteen to nineteen reported that their pregnancies were unintended (Finer & Henshaw, 2006). And yet teen women are viewed as being at fault, or at least responsible, by laws governing reproductive choices. This is even more startling given the prevalence of sexual coercion that young women experience. Twelve percent of girls in grades 9–12 reported having been physically forced to have sexual intercourse when they didn't want to (CDC, 2004, p. 39).

The issues of unintended pregnancies and coercion are of course not a problem for teens alone. The Guttmacher Institute reported that 49 percent of all pregnancies in the United States are unintended. Unintended pregnancy rates are substantially higher for women ages fifteen to forty who are living in poverty (58 percent unintended birth rate for the poorest women compared to 11 percent for the wealthiest) and those without a high school diploma (Finer & Henshaw, 2006). Of all unintended pregnancies, 48 percent end in abortion, as do 40 percent of unintended teen pregnancies.

Once young women find that they are pregnant, the state does little to enable her to make a "choice." For indigent women, the absence of Medicaid funding for abortion severely limits their access to abortion. As of 2006, only

seventeen states use public funds to pay for abortions for some poor women; four states cover the costs voluntarily, and thirteen do so under a court order (Guttmacher Institute, 2006a). Only about 13 percent of all abortions in the United States are paid for with public funds (Henshaw and Finer, 2003).

For women under eighteen, an additional obstacle to reproductive choice concerns parental consent for notification of their abortion, which has become nearly standard. As of June 2006, thirty-four states require some parental involvement in a minor's decision to have an abortion (Guttmacher Institute, 2006b). Placing serious constraints on minors seeking an abortion, these laws are designed to place familial and institutional barriers between young women and their right to a legal abortion. While the laws are regularly described as providing support to minors, in practice they only make the option of abortion less available and usually delay the procedure, putting girls' health (and potentially the fetus' health) increasingly at risk (Bitler & Zavodny, 2001; Ellertson, 1997; Griffin-Carlson & Schwanenflugel, 1998; Henshaw & Kost, 1992). To be clear, it is important to know that most young women already involve their mothers or a close relative in decisions about sexuality and reproduction. Even in states with no parental involvement laws, 66 percent of the young women report that they voluntarily involved at least one parent (Henshaw & Kost, 1992). Other estimates are that from 50 to 61 percent of all pregnant teens involved their parent(s) in their decisionmaking to remain pregnant or abort (Guttmacher Institute, 2005). For younger teens, age fourteen and below, 90 percent indicated that at least one parent knew, and that most parents supported their daughters' actions (Henshaw & Kost, 1992). African American teens are in fact more likely to discuss sexuality with their mothers than other groups; even those who sought judicial bypasses did so after telling their mothers about the pregnancy (Blum, Resnick, & Stark, 1990).

While involving families may be a form of support for some young women, there is a group of young women who do not have a parent or guardian to whom they can safely turn; many of these women have been sexually or physically abused at home (Schoen, Davis, & Collins, 1997). Henshaw and Kost (1992) found that of those who can't or won't tell parents about their pregnancy, 30 percent indicated they had experienced violence in their families, 30 percent feared more violence, and 18 percent feared pressure to leave home. Parental consent laws limit teen access to reproductive conversation and choice for precisely the young women most in need of supportive adults. And so too does geography.

Eighty-six percent of counties in the United States have no abortion provider, which means that 32 percent of women of reproductive age must travel out of their home county to obtain a legal abortion (Henshaw, 1998). While many factors undoubtedly influence a young woman's decision to have an abortion, variations in access, legal limitations, and Medicaid funding dramatically affect state rates of teenage pregnancies that end in abortion, ranging from 60 percent in New Jersey and 50 percent in New York, Massachu-

setts, and Washington, D.C., to the dramatically lower rates of 13 percent in Utah and Kentucky (Alan Guttmacher Institute, 2004).

If young women are expected to carry the burden of unwanted pregnancies or of abortion, why do they have to do so silently? According to the CDC report on "abortion surveillance" (Strauss et al., 2004), which reflects state-reported abortions only and does not include procedures performed by private physicians, 18 to 19 percent of all abortions are performed on teens. This is not a trivial matter that should be ignored in sexuality curricula.

### Sexually Transmitted Diseases

Evidence on venereal disease is also critical to a full understanding of the consequences of sexual behavior. In 2003, women age 13 to 19 accounted for half of the HIV cases in their age group. This number demonstrates the growing impact of HIV on women, and young women in particular. As a comparison, women age 20 to 24 accounted for only 37 percent of the HIV cases in their age group. Again, these numbers fall unevenly across ethnicities and most seriously affect women of color (for further discussion of HIV/AIDS data, see Kates & Carbaugh, 2006). Girls age ten to fourteen and fifteen to nineteen are more than six times more likely than their male peers to contract chlamydia, and those age fifteen to nineteen are almost three times more likely to contract gonorrhea, with the incidence of both conditions substantially higher for African American teens age fifteen to nineteen than Whites (Advocates for Youth, 2005). Young people most at risk for pregnancy and sexually transmitted diseases are also more likely to experience medical indigence, rely on publicly funded health care, and report lower rates of physician contact (Fulgini & Hardway, 2004; Office of Women's Health, 1998).

The wretched combination of rising drop out/push out rates, expansion of the criminal justice system into communities of color, and uninsured health care (Nussbaum, 2003) bodes poorly for young women's sexual health and reproductive freedom. As these young people are denied access to "enabling contexts"<sup>3</sup> for social and sexual development, we see, as Brown (2003) has described, how neo-liberalism operates such that "the state leads and controls subjects without being responsible for them." With the introduction and growth of funding and programming for AOUM curriculum in schools, many of these young women are taught to just say no — with no attention to the contexts in which they live, the institutions they inhabit, or the families in which they reside. When we read these statistics on sexual outcomes, we may blame (or pity) the young women themselves, either way camouflaging their (dis)abling contexts (Geronimus & Thompson, 2004). The cleverness of neo-liberalism lies in the strategic maneuver by which "subjects are controlled through their freedom . . . and neo-liberalism's moralization of the consequences of this freedom" (Brown, 2003). The state slips gently off the hook as the young woman stands alone, holding the consequences and the blame.



### *Taking Positions*

Two groups have distinct reactions to the material about teen sexuality and health outcomes presented above. Both agree that young people should be healthy and free of sexual coercion and that abstinence is a reasonable choice for adolescents. Both are anxious to reduce unintended pregnancies, STD rates, and all forms of sexual coercion. Where these two groups part ways lies in how they view young people's, and especially young women's, sexuality. One group — which includes most parents and educators (Dailard, 2001; Darroch, Landry, & Singh, 2000) — is committed to providing detailed information to young people about their bodies in order to encourage young women and men to make decisions that are driven by their own experience of sexual agency, desire, and an informed consideration of sexual dangers.

In fact, a national poll undertaken by National Public Radio, the Kaiser Family Foundation, and the John F. Kennedy School of Government (2004) found that 90 percent of parents of junior and senior high school students believed it was very or somewhat important to have sexuality education as part of the school curriculum, while 7 percent of parents did not want sex education to be taught in school at all (p. 5). Sixty-seven percent of parents of junior and senior high school students stated that federal government funding "should be used to fund more comprehensive sex education programs that include information on how to obtain and use condoms and other contraceptives," instead of funding programs that have "abstaining from sexual activity" as their only purpose (p. 7). People in this group argue that healthy sex lives are developed through comprehensive sexuality education, trusting relationships with adults and peers, and sufficient emotional and medical support in the form of contraceptives, access to abortion and child care, and protection against STDs. Healthy sexual lives require serious education and ongoing conversation about how to pursue pleasure, understand consequences, and protect against violence and coercion (see Tolman, 2002, 2006).

Another small but quite powerful and well-funded group sees the statistics on teen pregnancy, abortions, and STDs as evidence that sexual activity is inherently dangerous for young people. They believe that sexual health can be found only in adult, married, heterosexual relations. Against teen sexuality and for heterosexual marriage, this second group advocates for teaching sexual abstinence only until marriage. They maintain that if sexual behaviors are successfully halted — not discouraged — the dangerous aspects of sexuality will be avoided. As one abstinence advocate declared recently, "We don't tell them to smoke a little! We say 'Don't smoke!'" (Golden, 2005). Assumptions about the need to control sexual urges undergird this line of argument, as you can hear in the words of Claude Allen, the former assistant to the president for domestic policy, who justified the need for AOUM education as an obligation of the state: "If the choice is between self-restraint and self-destruction, the government can't be neutral. The government has to speak.

We need to encourage self-denial, self-restraint. They need to control their impulses" (Allen, 2005).

AOUM advocates argue that by teaching abstinence-only, social problems such as teen pregnancy, STDs, or family violence will be avoided because it is the act of sex that is seen as inherently injurious — both to the teen and to the social fabric (see Santelli et al., 2006a, for discussion). If all sexual activity were to cease prior to marriage, AOUM advocates argue those problems that stem from sex (STDs, psychological problems, etc.) would also cease. AOUM advocates argue that media, readily available contraception, and poor parenting encourage teen sex and that these circumstances cause family violence, incarceration, etc.

Disagreeing with this argument is not simply a matter of believing in different moral or family values. It is a matter of seeing the causal chain of events in a wholly different order and insisting that the implications for the policies be more fully considered. Instead of holding the act of unmarried teen sex — defined largely by the penetration of a woman by a man — responsible for causing social and psychological problems, advocates for comprehensive sexuality education place the genesis of social problems not in the act of teen sex, but in the uneven social contexts in which teens develop and sex occurs (see Advocates for Youth, n.d., for further discussion of the differences between comprehensive sexuality education and AOUM education).

Those advocating comprehensive sexuality education maintain that AOUM education requires an unrealistic expectation of sexual behavior; enforces gender rules that inhibit development of female desire; targets Black and Latino youth and reaffirms stereotypes about race and sexual promiscuity; takes money away from other public services, such as schools and clinics; inscribes and enforces a heterosexual marriage model (bringing in the family values rhetoric through the back door); sidelines LGBTQQ teens; censors teachers; undermines school-based conversations about sexuality and health clinic resources; and, ultimately, places blame for social ills on young women who are asked to bear the brunt of all subsequent social problems if they engage in sexual activity, either because they wanted to, were forced to, or felt compelled to for reasons other than their own sexual desire.

Indeed, abstinence models fail to provide adequate information for youth in general, but some are protected from the fall out. A thick desire framework begs the question of gender-, race-, and class-based consequences of AOUM, revealing that those who have insurance, confidential relationships with medical practitioners, and strong community supports may be able to endure the abstinence models and compensate if things go awry. For those lacking in material and social resources, these outcomes become publicly known and, as a result, only certain groups of youth become publicly known as "failures." Thus, abstinence models place a disparate burden on girls, youth of poverty, teens with disabilities, sexually abused young people, and LGBTQQ youth.

### **Sexual Surveillance: Implications for Educators**

Despite the press for AOUM, many teachers and health-care practitioners continue to teach the comprehensive sexuality curriculum, always with an opt-out provision for families that choose for their child to not participate in the class (for a discussion of the history of comprehensive sex education, see Goldfarb, 2005; Kirby, Alter, & Scales, 1979). Those who persist in teaching comprehensive sexuality education, however, report experiencing a “chill” on what they can and can’t teach, despite parents’ desire for comprehensive sexuality education. For example, more than nine in ten teachers believe that students should be taught about contraception, but one in four are prohibited from doing so (Darroch et al., 2000). At the school level, there are policies in place that enforce these silences within the classroom; 35 percent of public school districts require that abstinence be taught as the only option for unmarried people, and either prohibit the discussion of contraception or limit discussion to its ineffectiveness (Guttmacher Institute, 2002). There are regional differences as well: Over half of the districts in the South have an abstinence-only policy, compared with 20 percent of districts in the Northeast (Landry, Kaeser, & Richards, 1999). This chill of censorship in the classroom extends to the specifics of what is taught. For example, only 21 percent of junior high teachers reported that they taught the correct use of condoms in 2000; only 14 percent of U.S. school districts discuss abortion and sexual orientation (Kelly, 2005). Some school boards, like those in Franklin County, North Carolina, have ordered that chapters be sliced out of health books if they reveal more than what the abstinence-only state law permits (Kelly, 2005). In Lynchburg, Virginia, school board members refused to approve a high school science text until the illustration of a vagina was covered or cut out (Texas Citizens for Science, 2004).

Beyond censorship, a kind of sexual vigilantism has been unleashed by public school administrators, particularly in low-income schools and poorer communities. In 2004, the principal of a New York City middle school accused a group of thirteen and fourteen year-old girls of skipping school to attend a hooky party. The girls (not the boys) were suspended until they would submit to HIV, STD, and pregnancy tests, and the young women were required to turn the results over to the school (see New York Civil Liberties Union [NYCLU], 2004). In California, a high school principal called the mother of a young lesbian student to tell her about a series of “run-ins [the student had] with the principal . . . over her hugging, kissing, and holding hands with her girlfriend.” The student was not only counseled to leave her school, but her privacy rights were administratively violated as the principal “outed” her to her mother (Lewin, 2005, p. A21). The Gay-Straight Alliance Network has sued a number of districts, on behalf of students’ right to safety and freedom from harassment.

There have been reports in other communities of significant pressure on young women seeking contraceptive and pregnancy services to tell their par-

ents about receiving these services. This pressure to inform parents about students' reproductive choices has also extended to those who help the young women, even when a young woman has refused to include her parents in her health care and reproductive decisions. The Reproductive Rights Project at the NYCLU (2004) gathered a number of complaints from social workers, guidance counselors, and school personnel who were being required by administrators to contact parents about a student's pregnancy. Students' right to privacy and educators' professionalism are being undermined.

### *Dissent and Resistance*

Historically and today, there have been waves of resistance against the AOUM movement, launched by human rights groups, educators, feminists, lawyers, parents, youth, and health-care providers throughout the nation and globally. Despite a relentless and well-funded assault from the Right, over the past twenty years we have seen waves of a broad-based commitment to deep and comprehensive sexuality education by youth, educators, community members, and feminist lawyers. Thus, we consider this political moment to be an "interval," as Brown would argue,

a way of . . . telling the present's story differently. . . . Many of us experience the present as terribly closed. I think the opening that we have to cultivate is a kind of affective and intellectual [and we would add *pedagogical*] opening to political possibility that would help us read the present differently. (Brown, Colegate, Dalton, Rayner, & Thill, 2006, p. 37)

To see ourselves in an interval, rather than a political stranglehold, we offer a few images here of what these acts of resistance look like and the impact they are having. In the spirit of democratic access to education and public health, many are arguing for comprehensive sexuality education. In response to the well-funded and chilling campaign launched at the state and federal levels, in 2005, Representative Barbara Lee (D-CA) and Senator Frank Lautenberg (D-NJ) introduced the Responsible Education about Life (REAL) Act in Congress (H.R. 2553 and S. 368). Formerly known as the Family Life Education Act, REAL would allocate \$206 million federal dollars to states for medically accurate, age appropriate, comprehensive sex education in schools, including information about both abstinence and contraception (U.S. House of Representatives, 2005; U.S. Senate, 2005). This legislation spells out a few important differences that would be included in federal sexuality education requirements: for example, these curricula must "not teach or promote religion," stress "the value of abstinence while not ignoring those young people who have had or are having sexual intercourse," and insist that information "about the health benefits and side effects of all contraceptives and barrier methods" be provided to young people (Boonstra, 2002, p. 3). To date, over one hundred organizations, including the American Medical Association,

American Public Health Association, and the American Psychological Association, have come out publicly in support of this legislation (p. 2).

Moving from the national to the local level, we see communities organizing to resist the pressures and strings that come with federal funding. In Texas, scientists and educators have joined to create a website (<http://www.texscience.org>) where they can post informed protests against textbook censorship in their communities. The Colorado Council of Black Nurses returned \$16,000 in abstinence-only funding because they believed that the dollars interfered with responsible health education (Planned Parenthood, 2005b). Due to the organization and protests of adolescent health advocates and a group of high school students, the Board of Education of the Chicago Public Schools voted in 2006 to require its schools to offer comprehensive sexual education in grades 6–12, including information about contraception (Mendell, 2006). Finally, youth and youth advocates have created a series of websites for and by young women and young men, addressing questions of pleasure, danger, sexuality, and health for young people seeking information.<sup>4</sup>

Finally, there are a number of comprehensive sexuality education resources available for use in and outside of school settings (Bay-Cheng, 2003; Brick & Taverner, 2003; Brown & Taverner, 2001; Mabray & LaBauve, 2002; Mackler, 1999; SIECUS, 1998, 2004b; Taverner & Montfort, 2005). Community-based organizations, the Unitarian Church, and other groups serving youth have stepped up to the challenge and offered courses, seminars, and workshops on healthy sexual development (Unitarian Universalist Association, 2006a, 2006b). Rich sex education curricula remain available through SEICUS (2004b, 2005). In the face of a massive policy onslaught, there are seeds of resistance and mobilization in every sector of the nation.

It is important to note, further, that there is a curious history within the White House and the executive branch of strategic advocacy for pleasure and sexual health. Interestingly, over time, a number of African American members of the cabinet have challenged the abstinence-only campaign. Each was summarily punished thereafter. For example, in 1994 Surgeon General Jocelyn Elders commented that, “[masturbation] is an alternative. Now teenagers know that they’re not going to go blind, they’re not going to go crazy. Hair’s not going to grow on their hands. We need to just stop lying to our children” (Elders & Chanoff, 1996, p. 14). Elders was forced to resign her position soon thereafter. Years later, official talk against condoms was challenged when Colin Powell advocated for condom use on MTV and his comments were quickly retracted by the White House (Purdum, 2002). Echoes of these challenges were heard when Surgeon General David Satcher, also African American, ran into trouble with the Bush administration after publishing his extremely bold and comprehensive report, *The Surgeon General’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior* in 2001. The administration quickly distanced itself from the report.

Medical and public health organizations, educators, and government bodies are mobilizing across disciplines and professions to resist the trend toward censoring educators, suppressing science, and silencing young people's sexuality. In 2006, John Santelli and colleagues from Indiana University, George Washington University, the American College of Preventive Medicine, Mt. Sinai School of Medicine, and Human Rights Watch reviewed current federal policy and evaluations of abstinence education, including approaches to program evaluation (Santelli et al., 2006a). In their report, they framed the exclusive reliance on AOUM programs and policies as a human rights violation that

appears to be undermining more comprehensive sexuality education and other government-sponsored programs. We believe that abstinence-only education programs, as defined by federal funding requirements, are morally problematic, by withholding information and promoting questionable and inaccurate opinions. Abstinence-only programs threaten fundamental human rights to health, information, and life. (p. 1)

### Conclusion: Theorizing Thick Desire and Fantasizing Critical Sexuality Research

Thick desire places sexual activity for all people, regardless of age or gender, within a larger context of social and interpersonal structures that enable a person to engage in the political act of wanting. Wanting can be interpreted in any number of ways, but it necessarily positions a young person as feeling entitled to that which comes in the future. It includes wanting to have unhindered access to structural and institutional supports, such as education, health care, and protection from coercion. With wanting securely in place and thick desire as an organizing frame, it is possible to theorize about young women's sexual and reproductive freedoms not merely from a perspective of minimal loss, but from a perspective that sees them as entitled to desire in all of its forms; entitled to publicly funded enabling conditions across racial, ethnic, class, sexual, geographic, and disability lines.

This essay has interrogated two kinds of desire: the unbridled desire of the state and the religious Right to re-create public education in their own image, and the thick desire of youth to create lives filled with educational and economic opportunity, free of violence, and protected by knowledge of and resources for sexual and reproductive health. We have documented the geographic spread of the religious Right in terms of policy incursions into many of the "private" sites where young women and men seek assistance, resources, and support for healthy sexual development. And yet, more importantly, we want to leave the reader with a sense of how we might educate and research with the recognition that young minds, souls, and bodies *desire* broadly, in areas that are economic, educational, health-minded, and, indeed, sexual. That

is, young people carry thick desires for a tomorrow of meaning, hoping for rich enabling contexts where they can feed these desires in conversation with peers and elders (Chavkin & Chesler, 2005; Diamond, 2000; Levine, 2002; Lipman, 2005; Rose, 2003; Santelli et al., 2006a; Tolman, 2006).

To elaborate on a vision for critical sexuality studies, we argue that youth sexuality be theorized about and studied inside a stew of desires for opportunity, community, pleasure, and protection from coercion and danger. Adolescents need good schools, health-care, and freedom from violence (structural, institutional, family, and intimate) in order to develop healthy sexual subjectivities. Given this frame, sexuality and reproductive struggles must be linked to fights for equity in school finance, civil/queer/feminist/disability rights, health care, school and prison reform, affirmative action, and access to higher education. Economic, social, and corporeal struggles must be linked through the bodies, imaginations, dreams, and demands of young women and men.

Further, comprehensive sexuality education and youth development must help young women and men navigate across the dialectics of danger and pleasure. Risk cannot be severed from pleasure. They are braided, parasitic, nested inside one another. An exclusive focus on risk not only alienates, but also distorts the complexity of human relations and sexual desire. Therefore, it is naïve to educate for pleasure without attending to risk; but more perverse to imagine that teaching only about risk will transform human behavior.

We have also tried to advance, theoretically and methodologically, a framework for thinking through how state policy penetrates bodies at embodied intersections. We have tried to model how gender intersects with race, ethnicity, class, sexuality, disability, geography, and institutional biographies, and to document the disparate impact state laws, public policy, and educational practice have on differentially situated young bodies. Whether researchers rely on hierarchical linear modeling or sophisticated narrative analysis or both; whether we study youth in privileged communities or in long-neglected neighborhoods; whether we conduct life histories or delve into the statistical archives of seemingly unrelated public institutions like schools, prisons, and health clinics — this article is a call to recognize, study, and document how broadly and deeply state policies slice into the seemingly private lives of very differently situated youth, most particularly those with no private safety net.

Turning now to the question of sexuality education, we repeat the words of young people we met from various communities, ranging from those in extreme poverty to those more middle class. When we asked, “What do you need in the way of sexuality education?” young people were clear: “More conversations like this, where we’re asked what we think, what we want to know.” And yet, according to one of the speakers at the Network for Family Life Education conference in New Jersey in 2005, such pedagogical contexts are unfortunately growing extinct: “In sexuality education, talk is becoming a four-letter word” (Rodriguez, 2005).

We are tempted, of course, to argue that the era of comprehensive sexuality education is over in public schools, that educators and youth workers would be better off creating safe spaces for this kind of talk outside of schools, in local community centers, churches, synagogues, mosques, LGBTQQ community centers, health clinics, the YMCA, and the Girl Scouts. While we believe all of this should happen, we are more sure than ever that we cannot abandon schools — the place where all children and youth are required to attend, and attend together; the place where intellectual, political, and personal possibilities are inspired; where democracy, inquiry, and human rights are supposed to be fundamental.

Turning then to schools, we recognize that young people spend 30 percent of their day in classrooms; they are one of the most important places for talk, learning, and building skills. The evidence gathered here and confirmed in conversations with educators and youth, suggests that schools and school-based health clinics (see Geierstanger & Amaral, 2005) are precisely the places where young people can be engaged in safe, critical talk about bodies, sexuality, relationships, violence, contraception, abortion, disability rights, LGBTQQ struggles, gender equality, and sexuality as a human right. In language arts, history, science, math, and in courses on the visual and performing arts, young people can learn the skills of critical inquiry and democratic engagement, the power of dissent and action on one's own behalf and for a larger political project. Young people need to develop skills for finding key pieces of information and resources; building trusting relations with peers, adults, and professionals; speaking publicly for social justice (see Rogow & Haberland, 2005).

Though we take the question of *skill* seriously, we are concerned that the definition of skill within AOUM policies has atrophied. Skills to express political and sexual agency are just the kind of muscles young people need to develop in order to undertake critical analysis, trusting conversation, and help-seeking, and finally, to negotiate risk and pursue pleasure. Having skills merely to say no does not help young people make tough decisions, but instead simply drains decision-making from them and places them in the hands of more powerful others — the state, the media, advertisements, a partner, abuser, or predator. The echoes of lost skill reverberate for a lifetime in the student — we see the loss when a student is afraid to speak to a teacher or health practitioner or pharmacist about contraception or an STD; when he feels afraid to use a condom because he learned it will probably fail; when she finds herself not knowing that she is entitled to pleasure or to resist aggression; when she or he tries to find an identity as a lesbian, gay man, or transgendered person in a sea of “silver rings” (see Alwyn, 2004 for description of the “Silver Ring Thing,” a Christian abstinence group which encourages the use of silver rings to signify young people's pledges of abstinence until marriage) and promises of sexual bliss in the confines of marriage.

One young woman in a high school focus group explained to us, “I do not want to have sex until I am married. So I don't really need these conversa-



tions." Later in the group she spoke again, a bit less calm and detached, "But, when I am ready, where will I learn about contraception or even about what might feel good for me? Where will I learn about sexuality after high school? Will it magically happen when I marry?" Denied sexuality education, she will likely lack the knowledge, sense of entitlement, and skills to find out in the future what she doesn't know but needs to.

It is important to note that sexuality education is the *only* academic content area that is taught as if the knowledge gained in the classroom is meant to exclusively serve the young person's present situation. In an editorial in the journal *Contraception*, a group of physicians and medical researchers wrote, "School is intended to prepare young people with skills they need for the future. There is no controversy about good math education even though few teens have a compelling need for algebra in their daily lives" (Stewart, Shields, & Hwang, 2004, p. 345). A national commitment to abstinence only until marriage casts a wide net that will ensnare us all; it creeps into our imaginations and into our beds by prescribing a constricted form of sexual expression for young people, as well as adults, leaving clouds of shame, guilt, ignorance, and silence where knowledge, skills, and safe conversation should grow.

We introduced the concept of thick desire in this discussion, and we hope to make it a lens through which to conceptualize and evaluate youth-based education and social policies across public institutions. Instead of merely documenting risk and loss, we call for policies and research that recognize how macro-structures, public institutions, practices, and relationships affect "personal decisions," particularly for those without private supports and buffers. Thick desire is offered as a framework to move us away from mourning the "missing discourse of desire" and on to demanding more publicly subsidized educational, social, legal, economic, and health care supports for young people as they develop complex social and sexual biographies in adolescence and beyond. It is a way of evaluating policies, both local and global. Thick desire is meant to be a tool to see what is missing *and* to say what needs to be in place.

In this spirit, we invite educators, youth organizers, policy analysts, community activists, YMCA directors, health clinic professionals, and youth to create a surge of information and conversation about sexuality, power, and justice. Researchers, educators, community workers, lawyers, youth, and progressive clergy can come together to demand that thick desire be the benchmark — a progressive form of accountability — for measuring the extent to which a community supports full youth development (for an example, see the Forum for Youth Investment, <http://www.forumforyouthinvestment.org>). Campaigns and research projects for healthy youth development can be launched in schools, community centers, libraries, clinics, afterschool programs, and on the Internet, in which conversations about desire, danger, power, and bodies can be reclaimed as spaces for doubt, giggles, honesty, negotiation, struggle, pleasure, pain, and information. Young people are dying for good conversation about sexuality, and are dying without it.

## Notes

1. Structural violence is a form of violence that occurs when individuals are systematically denied rights, resources, and opportunities. Institutionalized racism, sexism, and ageism are examples of structural violence.
2. We use LGBTQ throughout this article to acknowledge the wide range of sexualities that do not necessarily manifest in same-sex sexual activities, but in how people choose to identify themselves. There is a 'queer' identity that is separate from lesbian, gay, bi, and transgender. Queer is a self-defined identity that encompasses people that may not be engaging in same-sex sexual activity, but may nevertheless be marginalized for nontraditional gender or sexual choices, and people who challenge the very use of sexual/gender/sexuality categories.
3. Correa and Petchesky (1994) define enabling contexts as those conditions and resources that aid in supporting individuals and groups.
4. For examples of websites, see the following: <http://www.Scarleteen.com>, "sex positive sex education"; <http://www.sxetc.org>, "a web site by teens for teens"; <http://www.MySistahs.org>, "by and for young women of color"; and <http://gURL.com>, "an online community and content site for teenage girls."

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## Notes on Contributors

DAVID ALLEN is a senior research associate at the National Center for Restructuring Education, Schools, and Teaching at Teachers College, Columbia University. His work has focused on authentic student assessment, teacher inquiry, and small schools. He has taught English and ESL in middle school, high school, college, and adult education settings. His most recent book is *The Facilitator's Book of Questions: Tools for Looking Together at Student and Teacher Work* (with T. Blythe, 2004).

JACQUELINE ANCESS is codirector of the National Center for Restructuring Education, Schools, and Teaching at Teachers College, Columbia University. Her research has focused on small high school reform, authentic assessment, and accountability. Her most recent book is *Beating the Odds: High Schools as Communities of Commitment* (2003). She was the founding director of a small public middle school in New York City and subsequently a district administrator for small school creation and big school conversions.

MICHELLE FINE is a Distinguished Professor of Psychology at The Graduate Center, City University of New York, where she has taught in the fields of urban education and women's studies since 1990. Her current research focuses on adolescent sexual subjectivities, women in prison, and participatory action research. Fine's work has appeared in journals including *Teachers College Record* and *Psychology of Women Quarterly*. Her recent coauthored books include *Working Method: Research, Critical Theory, and Social Injustice* (with L. Weis, 2004) and *Off White: Readings on Power, Privilege, and Resistance* (with L. Weis, L. P. Pruitt, and A. Burns, 2004).

SARA I. MCCLELLAND is a doctoral candidate in psychology at The Graduate Center, City University of New York. Her research concerns the regulation of adolescent sexuality, female sexuality and cancer, and the role of emotion in social psychology. Her work has appeared recently in journals including *Social Justice Research*, *Planning for Higher Education*, and *International Journal of Education Management*.

LUIS O. REYES is a visiting fellow at the Bronx Institute, Lehman College, City University of New York. His research has been published in numerous journals and other publications that have shaped bilingual education in New York City and the nation. His work addresses bilingual education policy, Latino education, dropout prevention, language rights, and multicultural education. He previously served as a member of the New York City Board of Education and as the director of the Office of Research and Advocacy for Aspira of New York, Inc.

JENNIFER SWIFT-MORGAN is an associate project director with Education Development Center in Newton, Massachusetts, where she manages projects on international education reform and provides technical assistance for program and training design re-