

Adolescent Sexuality

We are sexual from birth, and sexual expression is a basic human need throughout our lives.

Sexual expression is an essential component of healthy human development for individuals of all ages (Freud; Maslow *et al.*, as cited in Zimbardo, 1992; Tobias & Ricer, 1998). The majority of the public recognizes this fact — **63 percent of Americans believe that sexual exploration among young people is a natural part of growing up (SIECUS, 1999).** In fact, making the transition from childhood to a healthy sexual adulthood is considered to be one of the most important tasks of adolescence (Berman & Hein, 1999). The initiation of sexual intercourse during adolescence is a recognized pattern of behavior in the U.S. (Singh & Darroch, 1999), and by no means a recent one — premarital intercourse among young people, including many adolescents, was common well before World War II (Laumann *et al.*, 1994).

In recent decades, however, many of the milestones by which we measure and define adulthood — full-time employment, economic independence, domestic partnership/marriage, and childbearing — are attained at *later* ages in people's lives than they were in earlier generations, while puberty begins at *earlier* ages (AGI, 1994). The average age of menarche has

fallen significantly in the last century — in 1840 it was 16.5, and by the early 1990s it was 12.8 years of age (Herman-Giddens *et al.*, 1997; Rees, 1993), which means that adolescent women who experiment sexually are more likely to become pregnant at much younger ages.

Unlike their predecessors, young people today face many years between the onset of puberty, fertility, and the natural intensification of sexual feelings on the one hand, and marriage and economic independence on the other hand. As a result, young people have sexual intercourse earlier in life, and there are a greater percentage of adolescents who are sexually experienced at every age level, a greater number of acts of premarital intercourse, and a greater number of sexual partners before marriage (AGI, 1994; Kirby, 1997). The ensuing high rates of unintended pregnancy and sexually transmitted infections (STIs) among teenagers make it imperative that, among other things, we understand and identify the factors that are associated with early or late sexual initiation (Rosenthal *et al.*, 1999), and we provide all children and adolescents with responsible, age-appropriate, comprehensive, and medically accurate sexuality education and risk prevention programs. Such education and intervention must

also be realistic, meaning that programs and curricula must recognize the realities of adolescent sexuality and must not be based on abstinence alone.

In general, an adolescent's gender, age, socioeconomic status, family atmosphere, sexual orientation, religious commitment, and individual life experience are all factors that can exert an influence on whether, when, and how she or he will be sexually active. It is as true for teenagers as it is for adults that sexual expression can be either positive or negative depending on the context. Children who are reared in sexually negative environments may have more difficulty having sexually positive experiences. Serious damage is done when one person forces another to have sex, or when sex is used as a form of abuse or control. But, when engaged in voluntarily, safely, and responsibly, sex can engender not only pleasure but also a healthy intimacy and bond between two people. We know that the late adolescent (aged 17 to 21 years) is capable of forming mutually caring, intimate relationships based on trust, understanding responsibility and consequences, and making decisions about sex (AGI, 1994; Tobias & Ricer, 1998; Yarber & Greer, 1986).

We also know that some adolescents may have sex when the real needs they seek to satisfy may be to increase self-esteem, alleviate a sense of loneliness, meet societal expectations of what it means to be "masculine" or "feminine," express anger, or escape from boredom. During adolescence and throughout life, sex may be used as a way of expressing and satisfying nonsexual needs. Using sex in this way, however, may not meet such needs, and as a society we have a responsibility to teach our youth about this very human aspect of sexual expression (Hajcak & Garwood, 1988).

We live in a world saturated with images of and messages about sex — from movies, magazines, recordings, television shows, and advertisements that sell everything from soap to sports cars. Political and religious leaders have a lot to say about sex, too. Maturing adolescents are exposed to many of these conflicting messages which may help them or confuse them as they learn how to make healthy decisions about sexual behavior.

One of the most misguided and destructive messages that endangers adolescent health and life during this age of AIDS emanates from a vocal minority bent on suppressing or willfully ignoring the truth about sexual activity among adolescents in America. Under the guise of protecting our youth they declare, inaccurately, that premarital sex among adolescents is a relatively new and corrupt social phenomenon. They are not content to teach the benefits of delaying intercourse as one element of reasonable, responsible, and medically accurate sexuality education curricula. They say that society should tolerate no sexual activity among adolescents. They say that if *any* sexuality education is to be offered at all in the public schools, the only acceptable curriculum is one that not only endorses abstinence only and the postponing of sexual activity until marriage but also *actively withholds information* on how to prevent pregnancy and sexually transmitted infections.

Planned Parenthood Federation of America believes that a healthy society is one that

- acknowledges and values the fact that we are sexual beings throughout our lives
- recognizes that young people require open communication at home and at school in order to cope with their need for

- sexual expression and with the physiological processes of maturation
- has concern for the social, cultural, and economic forces that shape adolescent lives
- supports adolescent growth and development into responsible and fulfilled adulthood through the provision of responsible, medically accurate sexuality information and education

In a healthy society, adolescents can begin to learn

- how to meet nonsexual needs in meaningful ways
- how to delay the initiation of sexual intercourse until they have the physical, cognitive, and emotional maturity necessary for intimate sexual relationships
- how to make decisions that will preserve their physical and emotional well-being as they begin to explore one of the most basic, joyful, and meaningful aspects of existence
- how to avoid behaviors that put them at risk for unintended pregnancy and sexually transmitted infections when they decide to become sexually active

We believe that those who seek to legislate or otherwise compel abstinence-only sexuality education, and who uniformly condemn, on so-called “moral” grounds, all adolescent sexual activity — and, indeed, any non-marital, non-procreative sexual activity at any age — have ceded the moral ground by denying the realities of adolescent development, basic human needs and behavior, and healthy sexual expression. Their ahistorical, fear-ridden, repressive approach serves only to abandon young people at a time in their lives when they have the greatest

need for concrete information, education, and guidance from interested and caring adults — at home, at school, in the medical profession, and in all areas of public life.

Sexual Activity and Sexual Orientation Among Adolescents

The normal process of an adolescent’s development involves becoming less dependent on the family and paying more attention to the influence of peers. This is healthy, and in many ways can lead to positive behaviors — especially when the peer influences are positive. The struggle for parents and other caring adults is to give adolescents the skills and the guidance to make healthy choices. This can be challenging, given that young people are exploring their growing autonomy, their developing physical selves, and their relationships with others.

There are several developmental stages of adolescence through which we pass in order to integrate the elements of our sexual identities and become sexually healthy and sexually responsible adults. The elements of this integration include

- **physical maturation**
- **increased empathy for others**
- **increased desire for autonomy**
- **desire for parental guidance**
- **desire for intimacy with others**
- **increased identification with peers**
- **increased realization of sexual orientation**
- **increased realization of sexual preference**
- **periods of sexual abstinence**
- **periods of sexual experimentation**
- **initiation of first sexual intercourse**
- **postponement of sexual intercourse**

Adolescence can be categorized into three stages of development: early, middle, and late.

Although an individual adolescent will develop at her or his own unique pace, there are recognizable patterns of change in behavior and sexuality that occur from one stage of development to the next (Haffner, 1995).

In early adolescence (ages 9–13 for girls and 11–15 for boys), experimenting with sexual behavior is common, although sexual intercourse — vaginal, anal, or oral — is usually limited. During this stage, young adolescents begin the process of separating from the family and become increasingly influenced by their peers. Although young adolescents primarily engage in concrete thinking, and it is difficult for them to imagine future consequences, they continue to value their parents' guidance, especially on important life issues (Haffner, 1995).

In middle adolescence (ages 13–16 for girls and young women and ages 14–17 for boys and young men), the ability to think abstractly begins to develop. Separation from the family increases, and the desire to be accepted by one's peers can exert a strong influence on behavior. Sexual experimentation is common, and many adolescents have first intercourse during this stage of life (Haffner, 1995).

In late adolescence (young women aged 16 and older and young men aged 17 and older) the process of physical maturation is completed. The ability to understand abstract concepts is achieved by many adolescents at this stage, and many of them understand what the results and consequences of their actions and behaviors may be. There is an increased ability to empathize with others, give and receive intimacy, and define adult roles. There also is greater autonomy from the family as well as from the peer group, and

sexuality may become more associated with commitment and planning for the future (Haffner, 1995).

Awareness of sexual orientation often emerges in adolescence. In one study, 88.2 percent of 7th- to 12th-grade students described themselves as mostly or totally heterosexual, 10.7 percent as being "unsure," or "questioning," of their sexual orientation, 0.7 percent as bisexual, and 0.4 percent as mostly or totally homosexual. The percentage of students who were "unsure" steadily declined with age from 25.9 percent in 12-year-olds to five percent in 18-year-olds.

By age 18, the proportion of young men reporting primarily homosexual attractions and behavioral intent was 6.4 percent, which approximates the magnitude of Kinsey's 1948 projections (Kinsey *et al.*, 1948) of adult homosexuality — four percent of men exclusively homosexual throughout their lives and ten percent more or less exclusively homosexual for at least three years.

Compared with other students, questioning students were much less likely to report heterosexual experiences and more likely to report bisexual attractions as well as homosexual and bisexual fantasies. Young men were much more likely than young women to label themselves as mostly or totally homosexual. Older adolescents were more likely than younger students to report homosexual identities, attractions, and behaviors. The actual prevalence of bisexuality or homosexuality may be even greater than the percentage of students who *labeled* themselves as such (Remafedi *et al.*, 1992).

A number of retrospective studies published in 1980–81 found that while many adult gay men

remembered feeling different as children, most did not identify themselves as gay until they reached their late teenage years, and lesbians did not begin to believe that they might be homosexual until they reached, on average, the age of 18 (Haffner, 1995). However, a more recent, non-retrospective study of 14-to-21-year-old lesbian, gay, and bisexual youths had some different findings — the average age at which girls were certain of being lesbian/gay was 15.9, and the average age for boys was 14.6 years. The majority of young people in this study had a history of sexual activity with both sexes — 88 percent of the women and 95 percent of the men had had same-sex sexual activity, and 80 percent of the women and 56 percent of the men had had heterosexual sexual activity. Compared with the bisexual women who participated in this study, lesbians had significantly more women partners and fewer men partners, and gay men reported practically no women partners while bisexual men reported having about three women partners (Rosario *et al.*, 1996).

Percentage of Sexually Active Adolescents

In all cultures of the world, it is normal for people to begin sexual relationships as they get older. The cultural norms of different parts of the world vary, and a range of attitudes about adolescent sexual behaviors — from rigidly repressive to openly liberal — are sometimes found within the same communities. In the United States, there is no single national age of consent for sexual intercourse — states have a variety of statutes about the legality of sexual behaviors — and attitudes about adolescent sexual behavior are different from home to home.

The likelihood of having sexual intercourse increases steadily with age. In fact, few very young adolescents are sexually experienced in this way, and nearly 20 percent of adolescents do not have intercourse before they turn 20 (AGI, 1994).

In 1990, 1991, 1993, and 1995, 53 to 54 percent of students in grades 9–12 had had sexual intercourse. In 1999, however, only 49.9 percent of high school students reported having had sexual intercourse during their lifetime (CDC, 2000; Warren *et al.*, 1998).

Other findings comparing 1990–1995 rates to 1999 rates of sexual activity among 9th- to 12th-grade students are as follows:

- For the 1990–1995 period, a higher percentage of young men than young women students had sexual intercourse — 56.9 percent compared to 50.3 percent. In 1999, the same held true, but the percentages by sex were slightly closer together and were lower: 52.2 percent of

men and 47.7 percent of women were sexually experienced.

- From 1990–1995, the median age at first intercourse for all students was 16.5 years.
- In 1999, 38.6 percent of 9th–grade students, 46.8 percent of 10th–grade students, 52.5 percent of 11th–grade students, and 64.9 percent of 12th–grade students ever had sexual intercourse.
- For 1990–1995, 23.3 percent of boys and 13.8 percent of girls reported having four or more sexual partners. For 1999, the percentages decreased to 19.3 percent of boys and 13.1 percent of girls. (CDC, 2000; Warren, *et al.*, 1998)
- A 1990 national survey of youth between the ages of 12 and 17 found that among those who were sexually experienced, having sexual intercourse was episodic. When asked how many times in their lives they had sexual intercourse, boys reported slightly greater frequencies than girls, but these differences were small and not statistically significant (an average of 17.2 times for boys and 14.2 times for girls). As for how many times they had sex during the year prior to the survey, 86.7 percent of sexually experienced girls reported an average of 11.3 occurrences, and 90.4 percent of sexually experienced boys reported an average of 10.2 occurrences. In the month prior to the survey, 63.4 percent of sexually active girls reported having had sex an average of 3.5 times, and 58.1 percent of sexually active boys reported an average of 4.6 times (Leigh *et al.*, 1994).

- The proportion of adolescent women aged 15–19 who ever had sexual intercourse increased from 46.9 percent in 1982 to 52.6 percent in 1988, and then decreased to 51.5 percent in 1995. The proportion of those currently sexually active decreased from 43 percent in 1988 to 40 percent in 1995 (Singh & Darroch, 1999).

Adolescent Sexual Behaviors

As young people begin to experiment with sexual relationships, they learn what is pleasurable to themselves and to their partners. They may try a variety of behaviors they choose not to repeat, or discover others that become a part of their adult repertoire. The perception that “most people” practice a particular sexual activity may influence teens’ decision to experience it. The sexual norms of a community, or a particular school, can have an impact on the variety of sexual experiences an adolescent may experience.

Most adolescents experiment with a broad range of sexual behaviors from petting, to oral sex, to sexual intercourse.

A national survey of young men aged 15–19 conducted in 1995 found that

- more than half (55 percent) reported having ever had vaginal intercourse
- 53 percent had been masturbated by a woman or girl
- 49 percent had received oral sex
- 39 percent had given oral sex
- 11 percent had ever engaged in anal sex

This survey was also administered in 1988, and while the overall proportion of young men engaging in vaginal intercourse and oral sex did not change significantly by 1995, the proportion

who had been masturbated by a woman or girl increased greatly, from 40 percent in 1988 to 53 percent in 1995 (anal sexual activity was not measured in the 1988 study) (Gates & Sonenstein, 2000).

A 1994 national telephone survey of 9th- to 12th-grade students found that

- nearly all the students surveyed had engaged in kissing (90 percent) or “deep kissing” (78 percent)
- 72 percent had engaged in touching above the waist and 54 percent in touching below the waist
- 15 percent had engaged in mutual masturbation
- 55 percent of the seniors had experienced intercourse (the average age at first intercourse was just under 15, and 40 percent of all the sexually active teens had had sex at age 14 or younger)
- three-fourths of the students reported that they had had sex in their parents’ home
(Strasburger & Brown, 1998)

In 1984, 40 percent of 17- to 18-year-old girls had performed fellatio, while nearly a third of 17- to 18-year-old boys had performed cunnilingus. For 16 percent of the respondents, oral sex was not accompanied by subsequent intercourse (Strasburger and Brown, 1998). In 1999, it was reported that increasing numbers of students in middle schools in metropolitan Washington, D.C., eager to avoid pregnancy and not lose their virginity, were engaging in oral sex (Stepp, 1999).

Other surveys and studies, while not national in scope, document a wide range of adolescent sexual behaviors:

- A 1987–1989 study of young women and men aged 13–19 found that, in heterosexual activity, 70 percent of women and 59 percent of men had given oral sex to their partner, and 78 percent of women and 79 percent of men had received it. In addition, 20 percent of women and 27 percent of men reported at least one episode of heterosexual anal intercourse, and seven percent of both women and men had had same-sex sexual experiences (Moscicki *et al.*, 1993).
- A survey of women college students’ (aged 17–30) sexual practices at one large university in 1975, 1986, and 1989 found consistently that 87 percent were sexually experienced. The proportions of women engaging in anal intercourse, cunnilingus, and fellatio were not significantly different in the three study years — 10.3 percent in 1975, 7.5 percent in 1986, and 9.1 percent in 1989 had engaged in anal intercourse; 63.2 percent in 1975, 60.9 percent in 1986, and 65.2 percent in 1989 had engaged in cunnilingus; and 79.8 percent in 1975, 78.8 percent in 1986, and 86.3 percent in 1989 had engaged in fellatio (DeBuono *et al.*, 1990).
- A 1992 survey of 9th- through 12th-grade students in a socioeconomically diverse school district in Los Angeles County found that 47 percent of the students were virgins (never had heterosexual vaginal intercourse) — 53 percent of the adolescent women and 42 percent of the adolescent men. When these virgin students were asked about any heterosexual genital sexual activity that took place in the year prior to the survey, 29 percent reported that they had

engaged in masturbation of a partner, 31 percent reported having been masturbated by a partner, nine percent said they had engaged in fellatio with ejaculation, 10 percent said they had engaged in cunnilingus, and one percent said they had engaged in anal intercourse (Schuster *et al.*, 1996).

- In another study, junior high school students were interviewed on two occasions, first in 1980 and again in 1982. In the 1982 round of interviews, by which time many of the 1980 respondents were in high school, it was found that 25 percent of the virgin boys and 15 percent of the virgin girls had given or received oral sex. Among those who were virgin, cunnilingus alone was more frequent (10 percent of boys and seven percent of girls) than was fellatio alone (two percent of boys and two percent of girls), while 12 percent of virgin boys and seven percent of virgin girls had engaged in both activities. Among students who were not virgin, 19 percent of boys and 14 percent of girls had not engaged in oral sex; eight percent of boys and 16 percent of girls had engaged in cunnilingus alone; five percent of boys and two percent of girls had engaged in fellatio alone; and 69 percent of both girls and boys had engaged in both cunnilingus and fellatio (Newcomer & Udry, 1985a).

Adolescent Values About Sexual Activity

Young people's values are shaped by their families, their communities, and their life experiences. As they develop from concrete to more abstract thinkers, adolescents may express changeable beliefs and values about sexuality and other important aspects of their lives. They

often alternate between unrealistically high expectations and poor self-concept. Their judgments may be mature and accepting at one moment, and irrational and punitive the next. Moral development is not a straight, linear progression, and young people may experience and express conflicting values within a short period of time.

Adolescents' values about sexual activity are diverse and do not always predict their behavior.

- In 1999, of 1,038 adolescents between the ages of 13 and 17, 19 percent said that they had had sex, 49 percent stated that premarital sex is always wrong, and 48 percent said that it is sometimes permissible (Gribbin, 1999).
- In 1994, 9th- through 12th-grade students felt that the ideal age to begin having sex averaged out to 18.3 years — which was considerably older than the students' *actual* average age for beginning sexual relations, which was 14.8 years (Strasburger & Brown, 1998).
- In 1991, 63 percent of adolescents aged 13-15 and 65 percent of those aged 16-17 believed in practicing safer sex, and 32 percent of those aged 13-15 and 29 percent of those aged 16-17 believed in abstinence. In all, 61 percent of the young women and 67 percent of the young men believed in practicing safer sex, while 33 percent of the young women and 29 percent of the young men believed in abstinence (Chadwick & Heaton, 1996).
- In 1990, sexual restraint was valued by more than 50 percent of 6th- and 7th-

grade students, more than 45 percent of 8th-grade students, more than 30 percent of 9th-grade students, and more than 20 percent of 10th-, 11th-, and 12th-grade students (Chadwick & Heaton, 1996).

- perception of peer sexual activity
- feeling it's "the right time"
- approval of partner
- wanting to show love
- loss of self-control
- fear
- lack of readiness
- social disapproval

The Timing of and Feelings About First Sexual Intercourse

As most adolescents experience sexual intercourse before adulthood, their perceptions of "normal" behavior includes teenage sexual activity. Teens' first sexual experiences are often conflicted. They undergo intense emotions that may include sexual, romantic, intimate, and pleasurable feelings, along with fear, guilt, or shame. Adolescents may feel they are "ready" for sexual intercourse but be ambivalent about the specific conditions under which they will initiate or acquiesce to sexual activity. As these conflicting feelings and ambivalence are likely to be present in most young people before their first partnered sexual experience, it is difficult to pinpoint the degree of intention or consent.

The age of first sexual intercourse among adolescents is influenced by many factors:

- timing of puberty
- social controls
- frequent dating
- romantic relationships
- family constellations
- parental supervision
- economic status
- domestic violence
- sexual abuse
- physical attraction
- sexual curiosity
- peer pressure
- unrealistic appraisal of risks
- use of alcohol and other drugs

Boys appear to initiate intercourse earlier than girls, but girls catch up by the late teens (Leigh *et al.*, 1994). The timing of puberty is a significant influence for boys, while for girls it appears that social controls exert a greater influence than does the onset of puberty (AGI, 1994; Rosenthal *et al.*, 1999). Girls who are academically inclined, feel self-esteem, and have interests that are outside the dating culture, such as extracurricular activities at school, tend to delay their sexual "debut" (Bearman & Bruckner, 1999).

The more frequently and the earlier adolescents date, the earlier they have intercourse. Being in a romantic relationship is, for an adolescent girl, the most important factor in determining the timing of first sexual intercourse. Additional important, and not surprising, factors are the number and intensity of prior romantic partnerships and the degree of emotional closeness that exists in the current romantic partnership (Bearman & Bruckner, 1999).

Among the significant factors associated with delayed onset of sexual activity for both boys and girls are dual-parent families, higher socioeconomic status, parental supervision, and close relationships with parents. Poverty, violence, and lack of parental supervision are among the factors associated with early onset of sexual activity (AGI, 1994; Kirby, 1997; Leigh *et al.*, 1994; Rosenthal *et al.*, 1999).

Girls who are raised from birth by both parents, whether biological or adoptive, have lower probabilities of having sex at each age than teens who grow up in any other family situation. By the time they turn 16, 22 percent of girls from intact families and 44 percent of other girls have had sex at least once. By the age of 18, those percentages are 49 and 69 (Moore *et al.*, 1998). **Seventy-four percent of young women who had intercourse before age 14, and 60 percent of young women who had sex before age 15, reported having had sex involuntarily (AGI, 1994).**

In addition, while significant numbers of young women's first experience of sexual intercourse is voluntary and not forced, it is not always *wanted*. Young women's ambivalence toward their first sexual intercourse was revealed in a 1995 study. About a quarter of women nationwide between the ages of 15 and 24 who reported they had consented to their first intercourse had not entirely wanted it to happen (Abma *et al.*, 1998).

Women and men who recall childhood genital contact with adolescents or adults are nearly three times as likely to report having had their first vaginal intercourse by age 15 as those who did not have such experience (Laumann, 1996).

Of teenage women attending an urban-based adolescent medicine clinic, 41 percent (mean age of 14.5) had had consensual heterosexual experience. Fifty-eight percent had a current boyfriend, 31 percent reported a past boyfriend, and 11 percent had never had a boyfriend. Experienced girls, whose mean age of sexual initiation was 13.2 years, were more likely than inexperienced ones to share unique information with their boyfriends, spend time with them, and anticipate that their relationships would last longer. But most of the experienced girls felt that they had been "too young" at the time of first intercourse. They acknowledged that they had

not been ready to have sex, had not appreciated the potential risks, or had not made good decisions. Frequently cited reasons for having sex the first time were feeling physically attracted to a boyfriend, being curious about sex, being alone with a boyfriend and "it just happened," and being treated nicely by a boyfriend. There were a few girls for whom peer pressure was involved and, for many of these girls, the pressure came from other girls who were having sex (Rosenthal *et al.*, 1997).

In another study, similar personal and social factors for both girls and boys that influence the early initiation of sex were found to be

- a perception of being physically more mature than one's peers
- premature desire for and expectation of early autonomy from one's parents
- lower levels of self-restraint, for girls especially
- use of cigarettes, alcohol, and marijuana and, for boys especially, less common drugs such as benzodiazepines, heroin, cocaine, inhalants, and amphetamines (Rosenthal *et al.*, 1999)

Of teens surveyed in urban and rural family practice office settings, the age of first intercourse ranged from 11 to 18 years old, with the average age being 14.9. More than 39 percent of those who were 13–18 years old had had heterosexual intercourse. The factors that influenced the timing of sexual debut included the following:

- A much higher percentage of sexually active younger adolescents believed their peers to be sexually active, whether or not this perception was valid.

- Thirteen- and 14-year-olds who believed many or all of their peer group to be sexually active were more than 20 times as likely to have had their first coital experience than those who believed that none of their friends was sexually active.
- Teenagers younger than 15 were most frequently motivated to have sex for the first time by curiosity about sex, loss of self-control, wanting to show love, and feeling that it was "the right time."
- The most dominant reasons to refrain from having first intercourse were fear, lack of developmental readiness, and social disapproval.
- Personal morality was not a major influence on decisions to postpone first sexual intercourse.
- The most commonly reported reason for engaging in sexual intercourse was the active decision to do so, and lack of developmental readiness — defined in this study as a girl's not feeling ready, not being interested, and/or not having a boyfriend — was the most commonly reported reason for refraining.
- Among adolescents younger than 15 years old at the time of first intercourse, 16 percent reported peer pressure and eight percent reported self-esteem as the most important reasons for having intercourse. These reasons were less frequently cited as the most important reasons for sexual debut among older teenagers. Girls and boys both reported the importance of active decision making, loss of self-control, and peer pressure, although boys

were much more likely to report the latter two reasons.

- Fourteen percent of older teenagers reported that the first time they had sex, they were forced to.
- Twelve percent of girls reported that first intercourse was nonconsensual and another six percent reported that it was undertaken in order to enhance their self-esteem.

For girls who refrained from having first intercourse, lack of developmental readiness was more frequently cited as the reason, while fear — of STIs, HIV infection, or pregnancy — was more commonly cited by boys as the reason for refraining.

(Alexander & Hickner, 1997)

A study that focused on the role of peer norms in early sexual initiation of sixth-grade students found that those who were sexually initiated were significantly more likely than others to be older (11.9 years versus 11.6 years), male (58 percent versus 37 percent), attending a poorer school (87 percent versus 85 percent), and living in an area with a high proportion of single-parent families (45 percent versus 41 percent). They also more commonly reported engaging in nonsexual risk behaviors, such as drinking alcohol, participating in a fight, smoking cigarettes, and never wearing a bicycle helmet. In addition, they were more likely to perceive a high prevalence of sexual initiation among their peers, social gains associated with early sexual intercourse, and younger age of peers' sexual initiation.

The strongest predictor of sexual initiation among these sixth-grade students was entering sixth grade with a *high intention* to have sex, and the strongest predictor of having a high intention

was a student's belief that most friends had already done so. In this study, the difference in the mean ages of sexually initiated girls and boys is very narrow — 11.9 years for girls and 11.8 years for boys (Kinsman *et al.*, 1998).

Contraceptive Use

As contraceptive use has become the norm among a majority of Americans, it is becoming the norm for adolescents. Programs and policies that provide support for teen contraceptive use, and that increase access to reproductive health services, are making an impact.

Contraceptive use among adolescents has improved greatly since 1982. Contraceptive use depends on

- age
- fear of unintended pregnancy
- fear of sexually transmitted infection
- how much a woman wants to have sex
- positive attitudes toward condom use
- cognitive maturity
- use of alcohol and other drugs
- deference to partner

Two-thirds of adolescents use some method of contraception — usually the male condom — the first time they have sexual intercourse. The older a teenager is at first intercourse, the more likely she or he is to use a contraceptive (AGI, 1994).

Teenage women's contraceptive use at first intercourse rose from 48 percent in 1982 to 65 percent in 1988, almost entirely due to a doubling in condom use. By 1995, contraceptive use at first *voluntary* intercourse among women aged 15–19 rose to 78 percent, with two-thirds

of it being condom use (AGI, 1994; Moore *et al.*, 1998).

In 1999, 58 percent of currently sexually active high school students reported that they or their partner used a condom during their most recent sexual intercourse, and 16.2 percent reported that they or their partner had used birth control pills before their most recent sexual intercourse (CDC, 2000).

The trends clearly indicate that teenagers can simultaneously increase the use of condoms and reduce sexual activity. For the first time in decades, sexual activity among never-married men aged 15–19 is leveling off, condom use has increased, and the level of unprotected intercourse has fallen. These are significant findings, and they run counter to the claims of those who say that educating teenagers about condom and contraceptive use, and promoting the use of condoms, will lead to more sexual activity among teenagers (Sonenstein *et al.*, 1998).

Among never-married men aged 15–19

- There was a decline, from 60 percent in 1988 to 55 percent in 1995, in the proportion of teenage men who had had sex with women.
- Of those who were sexually active, 57 percent in 1988 used a condom at last intercourse. This proportion increased to 67 percent in 1995.
- The proportion of those who *always* used condoms during intercourse rose from 33 percent in 1988 to 45 percent in 1995, while the proportion of those *never* using condoms dropped from 18 percent in 1988 to 10 percent in 1995.

- The proportion of those who had had at least one act of unprotected sex within the last year fell from 37 percent in 1988 to 27 percent in 1995.
- The proportion who were sexually experienced but had been abstinent in the last year remained stable at six percent for 1988 and 1995. (Sonenstein *et al.*, 1998)

A young woman whose first partner is seven or more years older than herself is less likely than other women to use contraceptives at first intercourse, and she is more than twice as likely to rate first intercourse as unwanted than those women whose first partner is the same age or younger. The percentage of women who use contraception at first voluntary intercourse increases as the levels of wantedness rise (Abma *et al.*, 1998).

More than two-thirds of women aged 15–19 report long-term, uninterrupted contraceptive use, but they are more likely to report sporadic use and less likely to report uninterrupted use of a very effective method than are women aged 25–34. (However, adult women also use contraceptives less than perfectly. Women aged 20–24 have a higher rate of unintended pregnancy than do women in any other age group, and even among women aged 25 and older, one-third to one-half of all pregnancies are unintended.) (Glei, 1999)

The method teenage women use most frequently is the Pill (44 percent), followed by the condom (38 percent). About 10 percent rely on the injectable contraceptive, four percent on withdrawal, and three percent on the implant (AGI, 1999).

About one in six teenage women who practice contraception combine two methods, primarily the condom and another method (Piccinino & Mosher, 1998).

One study of young women aged 12–19, who were receiving reproductive health care at family planning, adolescent, sexually transmitted infection, and school-based health clinics, found that their use of condoms for at least one specific reason — prevention of pregnancy, prevention of infection in general, or prevention of HIV infection in particular — increased as cognitive maturity and positive attitudes toward condoms increased. Women who participated in more risk behaviors, such as drug and alcohol use and minor delinquency, were less likely to have used a condom (Orr *et al.*, 1992).

Among adolescent men, condom use is likely to be highest at the beginning of a relationship and to decline as the relationship continues. In 1991, the proportion of sexually active men aged 17–22 who used a condom with their most recent partner declined from 53 percent the first time they had intercourse with that partner to 44 percent at the most recent act of intercourse. Of those who had used a condom the last time they'd had intercourse, the main reasons given for doing so were to prevent pregnancy (83 percent), to prevent infection (12 percent), to prevent both pregnancy and infection (two percent), or to defer to a partner who insisted on it (three percent) (Ku *et al.*, 1994).

Condom use among adolescent men also decreases with age. Again in 1991, 59 percent of 17-to-18-year-old men used a condom the first time they had intercourse with their most recent partner, while only 56 percent of 19-to-20-year-old men and 46 percent of 21-to-22-year-old men did so. However, for the older men, the

probability that their sexual partner used the birth control pill the first time that the couple had sex increased — from 21 percent among 17-to-18-year-olds to 35 percent among 21-to-22-year-olds (Ku *et al.*, 1994).

Efforts to improve teenagers' access to contraception do *not* increase rates of sexual activity (Kahn *et al.*, 1999; Schuster *et al.*, 1998; Guttmacher *et al.*, 1997; Kirby, 1997). As one example, a condom availability program in a Los Angeles County high school did not cause an increase in sexual activity among the students, but it did increase condom use among those who were sexually active. One year after the program was implemented

- There was no significant change in the percentage of students who had ever had vaginal intercourse or of those who had had vaginal intercourse during the past year.
- Fifty percent of boys who participated in the program used condoms every time they engaged in vaginal intercourse during the past year, whereas only 37 percent of boys did so prior to the program.
- Eighty percent of boys used condoms for recently initiated first vaginal intercourse, up from 65 percent from before the program.
- Among girls, the self-reported likelihood of using a condom for vaginal intercourse did not change significantly for those

who had already experienced vaginal intercourse.

- There was a dramatic increase in anticipated condom use among students of both sexes who had never had vaginal intercourse prior to the program — from 62 percent at baseline to 90 percent at one-year follow-up among men, and from 73 percent to 94 percent among women.

In general, the students' attitudes toward sex and condom use either remained the same as it had been prior to the program or had changed in a direction that favored less sexual behavior and greater risk prevention (Schuster *et al.*, 1998).

Causes of High-Risk Sexual Behavior

Research on youth health behavior indicates that patterns of sexual risk behavior and their consequences are shaped by socioeconomic factors that include, among other things, neighborhood context, family structure, and class position (Ramirez-Valles, 1998). Other factors for high-risk behavior among teens include

- use of alcohol and other drugs
- history of sexual abuse
- working more than 20 hours a week
- homelessness
- suicidal ideation
- poor academic performance
- troubled relationship with parents
- lack of parental involvement
- less parent/child communication
- homophobia

Young people living or growing up in poor neighborhoods start their sexual activity at an

earlier age, report less contraceptive use, and have their first pregnancy at an earlier age. The resources made available — or not made available — to young people for their development into adulthood have an influence on their sexual risk behavior. Among the resources necessary to lessen risk behavior are greater access to jobs, support for single-parent families, improved quality of schools, and increased opportunities for community activities (Ramirez-Valles, 1998).

In the early teenage years, those who frequently smoke, drink, and use drugs are more likely than others to have sex (AGI, 1994). For both adolescent women and men, there is a strong association between alcohol use and having multiple sexual partners, and having multiple sexual partners increases the risk of acquiring STIs (Santelli *et al.*, 1998).

Early age of first sex is associated with more partners during the teen years. In 1992, more than half of those who experienced their first sexual intercourse by age 15 had at least four sexual partners by age 18, as compared to only 20 percent of those who were age 16 or 17 at the time of their first sexual intercourse (Laumann, 1996).

Girls who have been sexually abused tend to have more sexual partners than other adolescents, and a disproportionate number of teenage mothers have been victims of sexual abuse (Luster & Small, 1997).

Adolescents working 20 or more hours per week — in 1997 this meant nearly one in five teens — show increased risk of emotional distress, substance abuse, and early sexual activity (AGI, 1997).

Among homeless or runaway youth, sexual activity is high and condom use is relatively low (Anderson *et al.*, 1994).

One study of teenagers 13–19 years old in four rural midwestern counties examined the factors that distinguished between those who were sexual risk-takers (defined as having more than one sexual partner and rarely or never using contraception) from those who were either low-risk (defined as having only one partner and always using contraception) or who were sexual abstainers (defined as practicing sexual abstinence and having no sexual experience).

The young women who were sexual risk-takers were more likely than those in the low-risk group and the abstainers to

- have been sexually or physically abused
- contemplate suicide
- consume more alcohol
- have lower grade-point averages
- be less closely monitored by their parents
- receive lower levels of parental support
- not talk with their mothers about birth control (the low-risk, sexually active young women were more likely to have discussed birth control with their mothers than were the young women who were either high-risk or sexually abstinent/inexperienced)

Similar results were obtained for the young men in this study. As compared to low-risk or sexually abstinent/inexperienced young men, the young men who were sexual risk-takers also had higher levels of alcohol consumption and suicidal ideation, were much more likely to have been sexually or physically abused, received less parental monitoring and support, and had lower grade-point averages. However, unlike the findings for the young women, their parents were as likely (or as unlikely) to have discussed birth

control with them as were the parents of the low-risk, sexually active young men.

Parents can directly reduce the sexual risk-taking behaviors of their children by speaking to them openly and concretely about how to avoid unprotected intercourse, and by paying attention to their activities, school performance, and alcohol use. The researchers conclude, however, that adolescents who are sexual risk-takers are more likely than others to have troubled relationships with their parents and, therefore, need the help of other, responsible adults in order to lower their sexual risk-taking (Luster & Small, 1994).

Women aged 17 and younger whose current partners are more than three years older are significantly less likely to practice contraception than are peers whose partners are closer in age (Glei, 1999). And although the proportion of 15- to-17-year-old women who have a much older (i.e., more than six years older) partner is small, these adolescents are of concern because of their low rate of contraceptive use and their relatively high rates of pregnancy and birth (Darroch *et al.*, 1999).

Adolescents who live in dual-parent families and feel connected to their parents and schools are among those who are least likely to engage in risky behaviors, and they also delay first sexual intercourse. Associations have been found between higher risk sexual activity and unexcused school absence, staying out late without permission, stealing, and running away from home (Schuster *et al.*, 1996; Lammers *et al.*, 2000).

A survey of urban students who were at their appropriate grade levels showed that 19 percent of the sixth graders, 45 percent of the eighth

graders, and 60 percent of the 10th graders had had sexual intercourse. In comparison, however, for students who were in the same school district but who were below their appropriate grade levels, the rates were significantly higher: 44 percent of the sixth graders, 60 percent of the eighth graders, and 80 percent of the 10th graders had engaged in sexual intercourse (Barone *et al.*, 1996).

Nationwide from 1992-93, only 45.4 percent of "in-school" students aged 14-19 had had sexual intercourse. In comparison, however, 70.1 percent of "out-of-school" adolescents of the same age had had sexual intercourse ("out-of-school" adolescents were those who were not attending school and who had neither graduated from high school nor attained General Education Development credentials at the time of the interview). Furthermore, the out-of-school teenagers were significantly more likely to have had four or more sexual partners than the in-school teenagers (36.4 percent versus 14.0 percent) (CDC, 1994).

Sexual orientation can also be associated with health risk behaviors, often related to the violence and homophobia that are directed at gay, lesbian, and bisexual young people. In 1995, a Massachusetts study of 9th- to 12th-grade students found that gay, lesbian, and bisexual respondents were more likely than their peers to have been threatened with a weapon at school, to have had their property damaged at school, to have been involved in fights, and to have engaged in a variety of health risk and problem behaviors, including suicidal ideation and suicide attempts, use of multiple substances, and sexual risk behaviors. They were also more likely to have initiated risk behaviors at earlier ages than their peers (Garofalo *et al.*, 1998).

Providers of reproductive health care and family planning services should not assume that their pregnant adolescent clients are heterosexual or that adolescents who identify as lesbian, bisexual, or unsure of their sexual orientation are not in need of family planning counseling as well as interventions to prevent sexual and physical abuse. A 1987 study in Minnesota showed that adolescent girls who are lesbian or bisexual are about as likely to have had heterosexual intercourse as are adolescent girls who define themselves as heterosexual. In addition, they have significantly higher prevalences of pregnancy, physical or sexual abuse, and prostitution than girls who are either heterosexual or unsure of their sexual orientation (Saewyc *et al.*, 1999).

One of the most commonly repeated explanations for high-risk behavior among teens is that adolescents underestimate or ignore the probability of bad outcomes because they see themselves as invulnerable to such outcomes. That may be true, but their sense of invincibility may be due not to willfulness so much as to issues of maturation and cognitive processing (Strasburger & Brown, 1998). Recent studies indicate that teens may feel less invulnerable than do college students or adults. One study found that expressed perceptions of personal invulnerability *were not any greater for the adolescents* than they were for the adults — in fact, the adolescents *often judged themselves to have the greater risk*. These results indicate that society errs when it ascribes adolescent high-risk behaviors solely to a developmental stage. In so doing, parents run a costly risk — of failing to pay attention to other, more influential causes of such behaviors and, as a result, initiating attempts to prevent them that may prove ineffective (Quadrel *et al.*, 1993).

Cultural Influences on Adolescent Sexual Behavior

Public policies and laws regulate some sexual behaviors, religions describe acceptable and unacceptable behaviors based on their tenets, and social institutions from schools to the media give messages about sex, gender, and relationships. In this cultural mix of often-contradictory messages and influences, young people need accurate information, access to services, and guidance from trusted adults.

Family religious beliefs and practices, friends and peers, and cultural gender roles influence adolescent sexual behavior.

Religion

Adolescent sexuality and religious participation have reciprocal influences. Studies generally have shown that adolescents who value religion and who frequently attend religious services have less permissive attitudes toward premarital sex and are less experienced sexually. It has also been shown that adolescents who have permissive attitudes toward premarital sex tend to have reduced attendance at religious services (Thornton and Camburn, 1989). In fact, never-married sexually experienced women who attended religious services as adolescents are less likely than those who did not attend religious services as adolescents to have multiple sexual partners as adults (Seidman *et al.*, 1994). But while church attendance is an important determinant of delayed sexual activity, it may be so only when a child's friends attend the same church (Mott *et al.*, 1996).

Religious observance, however, does not provide an absolute barrier to adolescent sexual activity. A 1987 survey of 1,438 teenage members of

eight “born again” denominations showed that, by the age of 18, 43 percent had had sexual intercourse and 65 percent had participated in some form of sex play (intercourse or the fondling of breasts or genitals) (AGI, 1988).

Peer Relationships

Much influence from peers is of a positive nature.

For a girl, every one percent increase in the number of her friends who are at low risk of pregnancy decreases her own risk of pregnancy by one percent. And teenagers often negotiate conflicting influences from their peers — while one friend may present pressure to join a drinking game at a party, for example, another friend may simultaneously encourage leaving the party before things get out of hand (Bearman *et al.*, 1999).

Teenagers, like most people, commonly choose best friends who are like themselves. But they are also influenced by peers whom they admire or with whom they would like to develop closer ties. This suggests that they may be more inclined to change their behavior to fit into a new crowd than to maintain a current friendship (Bearman *et al.*, 1999).

It appears that most teenagers don't feel pressure to have sex before they are ready. In a 1988 poll, about 25 percent of 13-to-17-year-olds said that they had felt pressured by their peers to have sex. Among this group, young women were somewhat more likely than young men to have felt such pressure (AGI, 1994). Nevertheless, peer associations may be the strongest predictor of the frequency of adolescent sexual intercourse. Youth who resist engaging in sexual activity tend to have friends who are abstinent as well. They also tend to have strong personal beliefs in

abstinence and the perception of negative parental reactions. Youth who are sexually active tend to believe that most of their friends are sexually active as well; that rewards outweigh the costs of sexual involvement; that sex overall is rewarding; and that it is all right for unmarried adolescents older than age 16 to engage in intercourse (DiBlasio & Benda, 1990). Late in their teen years, college men report feeling most pressure from friends to be sexually active, while women report feeling more pressure from partners (Guggino & Ponzetti, 1997).

Masculinity Ideology

"Masculinity ideology" refers to beliefs about the importance of men adhering to culturally defined standards for male behavior. Some of these culturally instilled traditional beliefs are that

- men are always ready for sex
- guys should not act like girls
- a young man should be physically tough even if he's not big
- a man always deserves the respect of his wife and children

Sexually active, never-married men aged 15-19 who hold such traditional values, as compared to those who hold less traditional values

- view relationships between women and men as more adversarial
- have a greater number of sexual partners yet use condoms less consistently
- view condoms more negatively as reducing their sexual pleasure
- are less concerned with whether a partner wants them to use condoms
- believe less in a man's responsibility for preventing pregnancy

- believe more that making a woman pregnant is a validation of their masculinity

The public health consequences of the attitudes and beliefs inherent in masculinity ideology are unsettling, as are the personal consequences to the young men who hold them, in that they may face greater difficulties in establishing relationships of trust and intimacy with their sexual partners (Pleck *et al.*, 1993).

Hyperfemininity

For both women and men, the traditional, stereotypical gender roles are associated with an increased risk for involvement in sexual aggression (McKelvie & Gold, 1994).

Hypermasculine, or "macho," men who subscribe without question to the masculinity ideology are more likely to report engaging in sexually coercive behavior, and to indicate a greater hypothetical likelihood to rape in the future (Murnen & Byrne, 1991). Researchers have defined "hyperfemininity" as an exaggerated adherence to the stereotypic feminine gender role, and they have found that women who have high levels of hyperfemininity, as opposed to low- or non-hyperfeminine women

- are more accepting of adversarial sexual behavior
- blame themselves more when they experience sexual coercion
- more often believe that for a woman marriage is more important than a career and more often believe that it's more important for a potential spouse to have an economically successful, prestigious job than it is for themselves to have one
- are more likely to justify sexual coercion when the man involved is in a prestigious

position and thus more desirable for a relationship

- are more likely to suffer from psychological symptoms such as social- and self-alienation, feelings of inferiority, anxiety, and discomfort in expressing their opinions
- hold more negative attitudes toward other women
- have more traditional family attitudes

Some who have studied hyperfemininity suggest that it may be more reflective of a woman's general depression and low self-esteem, rather than adherence to the extreme gender role per se. Others point out the obvious, that the social structure that maintains an unequal power balance between men and women needs to change before sexual equality in heterosexual relationships could be the norm. Despite the second wave of feminism, this has not yet been achieved. Finally, far from blaming hyperfeminine women for their possible increased risk of sexual victimization, researchers point out that such women engage in consensual sexual experiences more often than do women who are low in hyperfemininity, and they are also more likely to date hypermasculine men — these factors increase the likelihood of eventually having a coercive experience (McKelvie & Gold, 1994; Murnen & Byrne, 1991). Clearly, hyperfeminine teen women may not have the coping skills to avoid these negative consequences — in fact, studies suggest that hyperfeminine behaviors and their consequences are reinforced throughout a woman's teen years, 20s, and early 30s (McKelvie & Gold, 1994).

Nonconforming Gender Identities

A transgendered person is anyone whose gender identity or expression differs from society's expectations of what it means to be a man or

woman. Transexuals are transgender people who find their gender identity — the sense of themselves as male or female — in conflict with their anatomical sex. In order to remedy this conflict, transexuals may live either part-time or full-time in their self-defined gender (Hirschfeld, 2000).

In a society such as ours that highly values macho men and feminine women and punishes gentle men and aggressive women, cross-gender behaviors have been stigmatized and punished (Bullough, 1994). Thousands of youth are aware by the time they reach school that their own inner sense of gender runs counter to the ways in which they are expected to express their gender to the outside world. As painful as this inner turmoil can be, it is often the threat of external danger — violence directed at them because of their gender expression — that imperils the lives of transgender youth (Hirschfeld, 2000).

The limitations of a society constructed upon narrow gender definitions makes it difficult for transgender youth to develop freely as human beings regardless of their anatomy. Just as administrators and educators have a responsibility to create safe and respectful schools for all, we as a society have an obligation to push not only for legal reform to prevent discrimination against those who are transgender, but also for education to raise awareness of the needs of transgender youth (Hirschfeld, 2000).

Parent-Teen Relationships/Communication

Parents are the primary and most important sexuality educators of their children. Providing children with sexuality education is an important

responsibility of parenthood. And most young people would prefer learning about sexuality from their parents. Whether they do it well or poorly, parents influence their children's attitudes and provide their basic education about sexuality. Too often, however, parents hesitate to speak directly with their children about sexuality. It can be uncomfortable to begin the discussion, and some parents may need help in figuring out what to say. Some mistakenly believe you can tell children too much too soon, and therefore harm them. The fact is you can't harm a child by giving accurate information about sexuality; you can't tell a child too much or too soon. Silence and evasiveness give children the message that they should not come to parents for information about sexuality.

The quality of the parent-teenager relationship, and the degree of a parent's openness to and comfort with discussing sex and sex-related topics, cannot be underestimated in terms of their influence on an adolescent's sexual values and behavior. The qualities of successful parent-teenager relationships and communication are

- **openness**
- **parental comfort with the issues**
- **beginning discussions at early age**
- **positive messages**
- **parental limit-setting**
- **closeness between child and parent**
- **flexibility**
- **absence of stress**
- **satisfying levels of intimacy**

Teenagers want to be able to talk to their parents about sex more than they do, and they believe that their parents can provide information that would be of great use to them. However, one-third of 15-year-old women said that neither of their parents had told them how pregnancy

occurs, and about half said that they had received no information on sexually transmitted infections or birth control from their parents (AGI, 1994; Bennett & Dickinson, 1980; Hutchinson & Cooney, 1998). Only 16 percent of young women and ten percent of young men cite their parents as their primary source of knowledge about sexuality (Ansuini *et al.*, 1996). Although parents are more likely than their children to report that they've provided sexuality education (King & Lorusso, 1997), most young people first learn about sex from friends, siblings, teachers, or the media, rather than from their parents (AGI, 1994; Ansuini *et al.*, 1996).

As young people get older, parental communication about sex does not improve to any appreciable extent (AGI, 1994). The result is that many adolescents are not aware of what their parents believe or feel about sex-related issues. When communication does take place, it may be initiated by the child rather than the parent (Rosenthal *et al.*, 1998), and adolescents and parents often contradict one another about the types of sex-related conversations they have had (Newcomer & Udry, 1985b). Or else the information that a parent provides may be quite limited, consisting largely of negative, nonverbal messages and the frequent use of warnings and rules rather than open discussion (Brock & Jennings, 1993).

Talking to teenagers about sex does not lead them to engage in sex earlier or more frequently. Although many parents fear that discussion will encourage sexual experimentation, the opposite is true — early parental communication on sex-related topics allows children to talk about sex and ask more questions and is associated with a delay in the onset of sexual activity. When sexual activity does take place, teenagers who have

discussed sexuality and sexual risk with their parents are

- more likely to talk about sexual health risks with their partners
- more likely to use condoms
- less likely to have multiple sexual partners

These responsible choices are even more likely if parents have been open in their communication, and skilled and comfortable in having these discussions. The degree of influence parents will have in these matters can depend on what they say and how they say it (Holtzman & Rubinson, 1995; Hutchinson & Cooney, 1998; Inazu & Fox, 1980; Ringel, 1999; Whitaker *et al.*, 1999).

Sexual behavior discussions between adolescent girls and their mothers have their strongest effects on sexual attitudes in the ninth and 10th grades. Toward the end of high school, and particularly in college, peer approval becomes more influential than parent communication (Treboux & Busch-Rossnagel, 1995).

The more satisfaction teens feel with the mother-child relationship, the less likely they are to be sexually experienced. The more they perceive their mothers' disapproval of premarital sex, the less likely they are to engage in sexual intercourse and, if already sexually active, they will engage in sexual intercourse less frequently and use contraception more consistently (Inazu & Fox, 1980, p. 98; Jaccard *et al.*, 1996). As compared to children whose relationships with their mothers have a distant quality, those who are close to their mothers are more likely to have attitudes and behaviors that are consistent with their mothers' own attitudes (Weinstein & Thornton, 1989).

A teenager's ability to talk to parents about such things as birth control, sexual responsibility, positive and negative feelings about sex, and the meaning of sex in intimate and loving relationships, is strongly associated with her/his perception of the parents as engaging in open communication, and with how open, flexible, and adaptive to change the family context is (Papini *et al.*, 1988).

The quality of parent/adolescent communication about sex-related issues has been measured in the following terms:

- how comfortable the adolescent feels in approaching parents with questions or concerns about sex
- whether or not the adolescent fears that parents will think that, because she or he is asking such questions, she or he may be interested in experimenting with sex
- whether or not the adolescent feels that parents will withhold information when such questions are asked
- whether or not the adolescent feels that parents will understand and care about her/his feelings when they talk together about sex

This study found that although the quality of parent/adolescent communication may not affect the adolescent's sexual behaviors directly, it does affect the adolescent's sexual values and intentions and, therefore, has at least an *indirect* effect on sexual behaviors (Miller *et al.*, 1998).

Poor parent-child relationships are associated with depression in adolescents. For young men, this may lead to more frequent use of alcohol, which is strongly linked with early sexual activity. For young women, estrangement at home often leads them to seek and establish intimate relationships outside the family, in order to

experience the warmth and support they lack at home. Disagreements with parents that persist or escalate are sources of stress in an adolescent's life that, over time, increase the risk of onset of depressive or anxiety disorders (Rueter *et al.*, 1999; Whitbeck *et al.*, 1992).

Sexuality Education

Sexuality education occurs in many settings. One important venue for this education is in schools. While there is some disagreement about the intended outcomes for sexuality education, most professionals agree that it has an intrinsic value in helping young people to acquire information and skills that contribute to the likelihood that they will grow into sexually healthy adults. As with most education, sexuality education provides learners with information, builds skills such as critical thinking and decision making, and provides a context for discussion, values clarification, and exchange of ideas.

Responsible, medically accurate sexuality education helps young people make responsible choices about their sexual and reproductive health and is supported by the majority of Americans (SIECUS, 1999).

An influential minority of individuals promote unrealistic, abstinence-only education and parental involvement requirements for obtaining contraception that deny American teens accurate information about and confidential access to family planning services to prevent pregnancy. However, even individuals who support mandatory parental involvement and abstinence-only programs recognize the dangers of such measures. For example, in a 1998 debate over mandating parental involvement for teens using

Title X–funded clinics for contraceptive services, Rep. Tom Coburn (R–OK), a radical opponent of family planning, conceded that "if we put in the [parental notice] language, some additional young women will get pregnant [and] some will get a sexually transmitted disease" because they will be deterred from seeking out services when they are no longer guaranteed confidentiality (Saul, 1999).

Planned Parenthood believes that policymakers must accept the fact that teens engage in sexual behavior, and they must initiate and provide funding for various programs and interventions that will facilitate responsible sexual behavior.

Responsible, medically accurate sexuality education can help prevent teenage pregnancy.

Responsible, medically accurate sexuality education that begins in kindergarten and continues in an age–appropriate manner through the 12th grade is necessary given the early ages at which young people are initiating intercourse. In fact, the most successful programs aimed at reducing teenage pregnancy are those targeting younger adolescents who are not yet sexually experienced (Frost & Forrest, 1995).

Balanced and realistic sexuality education programs that encourage students to postpone sex until they are older, and also promote safer sex practices for those who choose to become sexually active, have been proven effective at delaying first intercourse and increasing use of contraception among sexually active youth. These programs have *not* been shown to initiate early sexual activity or to increase levels of sexual activity or numbers of sexual partners among sexually active youth (Berne & Huberman, 1999; Kirby, 1997).

Many sexuality education programs in the United States currently caution young people to not have sex until they are married. Of the 69 percent of school districts with a policy to teach sexuality education, 86 percent promote abstinence as the preferred or the *only* option for adolescents (Landry *et al.*, 1999). Abstinence–only education has become increasingly prevalent. In 1988, only two percent of sexuality education teachers taught abstinence as the only way of preventing pregnancy and STIs, as compared to 23 percent in 1999 (Darroch *et al.*, 2000). However, abstinence–only programs are ineffective: they fail to delay the onset of intercourse and often provide information that is medically inaccurate and potentially misleading (Berne & Huberman, 1999; Kirby, 1997). Only nine states require sexuality education that includes information about contraception. Five other states require that *if* sexuality education is provided, it must include information about contraception (NARAL, 2000).

The vast majority of Americans support sexuality education for teenagers — 93 percent believe it should be taught in high schools, and 84 percent believe it should be taught in middle or junior high schools (SIECUS, 1999). Teenagers also express the need for medically accurate, responsible sexuality education.

- Nearly half of high school students nationwide report that they need basic information on birth control, HIV/AIDS, and other sexually transmitted infections (STIs), and nearly half are unaware that an STI increases the risk of getting HIV if sexually active.
- Forty–two percent of students would like more information on where to get contraception; 32 percent would like more

information on how to use condoms; and 54 percent would like more information on where to go to get tested for HIV and STIs.

- Fifty-two percent of students do not know birth control pills can be obtained without parental permission; 31 percent do not know condoms can be purchased without parental permission; and one in four do not know free or low-cost family planning services are available for people under the age of 18. (KFF, 2000)

Responsible, medically accurate sexuality education is a success in other developed nations. European countries have already demonstrated great success with responsible, medically accurate sexuality education. For example

- The Netherlands, where sexuality education begins in preschool and is integrated into all levels and subjects of schooling, boasts the lowest teen birthrate in the world — 6.9 per 1,000 women aged 15–19 — a rate almost eight times lower than that of the U.S. Likewise, the Dutch teenage abortion rate is more than three times lower than that of the U.S., and its overall AIDS case rate is more than eight times lower.
- In Germany, where sexuality education is comprehensive and targeted to meet the reading and developmental needs of the students, the teenage birth rate is more than four times lower than that of the U.S., and its overall AIDS rate is 11.5 times lower.

- France has a nationally mandated sexuality education program that begins when students are 13. Parents are prohibited from withdrawing their teenagers from the program. France's teenage birth rate is approximately six times lower than that of the U.S., its teenage abortion rate is more than two times lower, and its overall AIDS rate is more than three times lower. (Berne & Huberman, 1999; Singh & Darroch, 2000)

The most effective programs in the U.S. combine abstinence education with medically accurate information on a variety of sexuality-related issues, including contraception, safer sex, gender identity, sexual orientation, and the risks of unprotected intercourse and how to avoid them, as well as the development of communication, negotiation, and refusal skills. Such programs have been shown to delay the premature onset of sexual initiation among younger adolescents by as much as 15 percent and to increase contraceptive use among older adolescents by as much as 22 percent (Brindis, 1999; Frost & Forrest, 1995).

However, sexuality educators face formidable barriers in delivering the comprehensive sexuality programs that adolescents need and want. Nearly half of sexuality education teachers report that more time needs to be devoted to sexuality education (KFF, 2000). Of the two-thirds of teachers who teach a school mandated curriculum, half report that they are restricted from answering students' questions about topics not included in the curriculum (Landry *et al.*, 2000). Some of the topics that teachers have been forbidden from discussing in abstinence-only curricula include condoms, abortion, or

homosexuality (Landry *et al.*, 2000; Sears, 1992). One-third of teachers said they had to be careful about what they taught because of the possibility of adverse community reactions (Darroch *et al.*, 2000). Teachers and schools must be given the time, resources, and support to deliver the most effective sexuality education programs.

Conclusion

Clearly, adolescents are sexually active. Planned Parenthood Federation of America believes that society has a responsibility to address this reality directly rather than deny it, fear it, revile it, or attempt to wish it away.

Adolescents are capable of making responsible choices about their sexual behavior, but they can only make those choices if society — from parents to politicians, from communities to schools, from the media to the medical profession — shows them how to do so. This can be accomplished by providing

- responsible, medically accurate sexuality education
- positive and open communication about sex and sexual health in the public and private arenas
- real cultural and economic opportunities that give young people hope for their futures and a personal stake in their society
- guidance, understanding, and support to help them navigate the complex stages of adolescent development

If, as a society, we help adolescents make responsible choices about their sexual health and development, we can fulfill our basic responsibilities to them and to ourselves.

Additional Resources

Advocates for Youth
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
202-347-5700
202-347-2263 (fax)
info@advocatesforyouth.org
www.advocatesforyouth.org

The Alan Guttmacher Institute (AGI)
120 Wall Street, 21st Floor
New York, NY 10005
212-248-1111
212-248-1951 (fax)
AND
1120 Connecticut Avenue, NW, Suite 460
Washington, DC 20036
202-296-4012
202-223-5756 (fax)
info@agi-usa.org
www.agi-usa.org

Gay, Lesbian and Straight Education Network (GLSEN)
121 West 27th Street, Suite 804
New York, NY 10001
212-727-0135
212-727-0254 (fax)
glsen@glSEN.org
www.glsen.org

Kaiser Family Foundation (KFF)
2400 Sand Hill Road
Menlo Park, CA 94025
650-854-9400
650-854-4800 (fax)
www.kff.org

The National Campaign to Prevent Teen
Pregnancy
1776 Massachusetts Avenue, NW, Suite 200
Washington, DC 20036
202-478-8500
www.teenpregnancy.org

Sexuality Information and Education Council of
the United States (SIECUS)
130 West 42nd Street, Suite 350
New York, NY 10036-7802
212-819-9770
212-819-9776 (fax)
siecus@siecus.org
www.siecus.org

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Media Contacts — New York: 212-261-4660 / Washington, DC: 202-973-6397

Public Policy Contact — Washington, DC: 202-785-3351