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Teen Sex: Truth and Consequences

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Ten million teen-agers will engage in about 126 million acts of sexual intercourse this year.

As a result, there will be about 1 million pregnancies, resulting in 406,000 abortions, 134,000 miscarriages and 490,000 live births.

Of the births, about 313,000, or 64 percent, will be out of wedlock.

And about 3 million teen-agers will suffer from a sexually transmitted disease, including AIDS.

This epidemic of teen pregnancy and infection has set off firestorms of debate in school systems across the country. Both sides have rallied around the issue of condom distribution as if it were a referendum on teen sexuality.

Proponents argue that teen-agers will have sex whether contraceptives are available or not, so public policy should aim to reduce the risk of pregnancy and the spread of sexually transmitted diseases by making condoms easily available.

Opponents claim that such policies implicitly endorse teen sex and will only worsen the problem.

The causes of teen pregnancy and sexually transmitted diseases, however, run much deeper than the public rhetoric that either side suggests. Achieving real change in the sexual behavior of teen-agers will require action on a broader front.

More active and younger

Some things are not debatable: Every year, more teen-agers are having more sex, they are having it with increasing frequency, and they are starting at younger ages.

There are four principal sources of information about the sexual practices of teen-agers: the National Survey of Family Growth, a national in-person survey of women ages 15-44 conducted in 1982 and again in 1988; the National Survey of Adolescent Males, a survey of males ages 15-19 conducted in 1988 and 1991; the National Survey of Young Men, a 1979 survey of 17-to l9-year-olds;

andthe Youth Risk Behavior Survey, a 1990 questionnaire-based survey of 11,631 males and females in grades 9-12 conducted by the Centers for Disease Control. In addition, the Abortion Provider Survey, performed by the Alan Guttmacher Institute, collects information about abortions and those who provide them.

With minor variations caused by differences in methodology, each survey documents a sharp increase in the sexual activity of American teen-agers. All these surveys, however, are based on the self-reports of young people and must be interpreted with care.

For example, one should always take young males' reports about their sexual exploits with a grain of salt. In addition, the social acceptability of being a virgin may have decreased so much that this, more than any change in behavior, has led to the higher reported rates of sexual experience. The following statistics should therefore be viewed as indicative of trends rather than as precise and accurate measures of current behavior.

A cursory glance at National Survey on Family Growth reports shows that there was indeed a sexual revolution. Teen-agers in the early 1970s were twice as likely to have had sex as were teen-agers in the early 1960s.

The trend of increased sexual activity continued well into the late 1980s. Rates of sexual experience increased about 45 percent between 1970 and 1980 and increased another 20 percent in just three years, from 1985 to 1988, but rates have now apparently plateaued. Today, over half of all unmarried teen-age girls report that they have engaged in sexual intercourse at least once.

These aggregate statistics for all teen-agers obscure the second remarkable aspect of this 30-year trend: Sexual activity is starting at ever-younger ages. And teens are not only having sex earlier, they are also having sex with more partners. Almost 7 percent of ninth-grade females told the Youth Risk Behavior Survey in 1990 that they had had intercourse with four or more different partners, while 19 percent of males the same age reported having done so. By the 12th grade, 17 percent of girls and 38 percent of boys reported having four or more sexual partners.

A major component of these increases has been the rise in sexual activity among middle-income teen-agers. Between 1982 and 1988, the proportion of sexually active females in families with incomes equal to or greater than 200 percent of the poverty line increased from 39 percent to 50 percent. At the same time, the proportion of females from poorer families who had ever had sex remained stable at 56 percent.

Until recently, black teens had substantially higher rates of sexual activity than whites. Now, the differences between older teens of both races have narrowed. But once more, these aggregate figures obscure underlying age differentials. For males and females, the gap narrowed between the 15-year-old and 18-year-old groups.

Finding birth control

Many people believe that there would be less teen pregnancy and sexually transmitted diseases if contraceptives were simply more available to teen-agers, hence the call for sex education at younger ages, condoms in the schools, and expanded family planning programs in general. (In Florida, a task force appointed by the governor has recommended that condoms be made available to high school students. Some school districts in Central Florida have passed resolutions against the idea.)

But an objective look at the data reveals that availability is not the prime factor determining contraceptive use. Almost all young people have access to at least one form of contraception. In a national survey conducted in 1979 by Melvin Zelnik and Young Kim of the Johns Hopkins School of Hygiene and Public Health in Baltimore, more than three-quarters of 15-to 19-year-olds reported having had a sex education course, and 75 percent of those who did remembered being told how to obtain contraception.

Condoms are freely distributed by family planning clinics and other public health services. They are often sitting in a basket in the waiting room. Edwin Delattre, acting dean of Boston University's School of Education and an opponent of condom distribution in public schools, found that free condoms were available at eight different locations within a 14-block radius of one urban high school.

And, of course, any boy or girl can walk into a drugstore and purchase a condom, sponge or spermicide. Price is not an inhibiting factor: Condoms cost as little as 50 cents. Although it might be a little embarrassing to purchase a condom - mumbling one's request to a pharmacist who invariably asks you to speak up used to be a rite of passage to adulthood - young people do not suffer the same stigma, scrutiny or self-consciousness teen-agers did 30 years ago.

Teen-agers can also obtain contraceptives such as pills and diaphragms from family planning clinics free of charge or on a sliding fee scale. In 1992, more than 4,000 federally funded clinics served 4.2 million women, some as young as 13. In all states except Utah, teen-agers can use clinic services without parental consent. To receive free services under the Medicaid program, however, a teen-ager must present the family's Medicaid card to prove eligibility.

The evidence suggests that as with condoms, teens know how to find a clinic when they want to. When they are younger, they do not feel the need to go to a clinic since condoms tend to be their initial form of contraception.

Susan Davis of Planned Parenthood explains, "The most common reason teen-agers come is because they think they are pregnant. They get worried. Or they get vaginal infections."

The median time between a female teen-ager's first sexual experience and her first visit to a clinic is one year, according to a 1981 survey of 1,200 teen-agers using 31 clinics in eight cities conducted by Laurie Zabin of Johns Hopkins.

Two pieces of evidence further dispel the notion that lack of availability

of contraception is the prime problem. First, reported contraceptive use has increased even more than rates of sexual activity. By 1988, the majority of sexually experienced female teens who were at risk to have an unintended pregnancy were using contraception: 79 percent. In addition, the proportion of teen females who reported using a method of contraception at first intercourse increased from 48 percent in 1982 to 65 percent in 1988.

The second piece of evidence is that as they grow older, teen-agers shift the forms of contraception they use. Younger teens tend to rely on condoms, whereas older teens use female-oriented methods, such as a sponge, spermicide, diaphragm or the pill, reflecting the greater likelihood that an older female will be sexually active.

A major reason for this increase in contraceptive use is the growing number of middle-class youths who are sexually active. But it's more than this. Levels of unprotected first sex have decreased among all socioeconomic groups. Unprotected first sex also decreased among racial groups.

It's not just that teens are telling interviewers what they want to hear about contraception. Despite large increases in sexual activity, there has not been a corresponding increase in the number of conceptions. Between 1975 and 1988, when about 1.3 million more teen females reported engaging in sex (a 39 percent increase), the absolute number of pregnancies increased by less than 21 percent.

Too often unprotected

Although the conception rate among teens is declining, the enormous increase in sexual activity has created a much larger base against which the rate is multiplied. Thus there have been sharp increases in the rates of abortion, out-of-wedlock births, welfare dependency and sexually transmitted diseases as measured within the whole teen population.

Teen-age sexuality does not have to translate into pregnancy, abortion, out-of-wedlock births or sexually transmitted diseases. Western Europe, with roughly equivalent rates of teen sexuality, has dramatically lower rates of unwanted pregnancy.

The magnitude of the problem is illustrated by data about reported condom use. Between 1979 and 1988, the reported use of a condom at last intercourse for males ages 17-19 almost tripled, from 21 percent to 58 percent.

A decade of heightened concern about AIDS and other sexually transmitted diseases probably explains this tripling. According to Freya Sonenstein and her colleagues at the Urban Institute, more than 90 percent of males in their sample knew how AIDS could be transmitted. Eighty two percent disagreed "a lot" with the statement, "Even though AIDS is a fatal disease, it is so uncommon that it's not a big worry."

As impressive as this progress was, 40 percent did not use a condom at last intercourse. In fact, the 1991 National Survery of Adolescent Men found that there has been no increase in condom use since 1988 - even as the threat of

AIDS has escalated.

The roots of too-early and too-often unprotected teen sex reach deeply into our society. Actor Robin Williams reportedly asked a girlfriend, "You don't have anything I can take home to my wife, do you?" She said no, so he didn't use a condom. Now both Williams and the girlfriend have herpes, and she's suing him for infecting her. (She claims that he contracted herpes in high school.) When fabulously successful personalities behave this way, should we be surprised to hear about an inner-city youth who refuses his social worker's entreaties to wear a condom when having sex with his AIDS-infected girlfriend?

This is the challenge before us: How to change the behavior of these young men as well as the one in five sexually active female teens who report using no method of contraception.

First, all the programs in the world cannot deal with one vital aspect of the problem: Many teen-agers are simply not ready for sexual relationships. They do not have the requisite emotional and cognitive maturity. Adolescents who cannot remember to hang up their bath towels may be just as unlikely to remember to use contraceptives. Current policies and programs do not sufficiently recognize this fundamental truth.

At the same time, the clock cannot be turned all the way back to the innocent 1950s. Sexual mores have probably been permanently changed, especially for older teens - those who are out of high school, living on their own or off at college. For them, and ultimately all of us, the question is: How to limit the harm being done?

The challenge for public policy is to pursue two simultaneous goals: to lower the rate of sexual activity, especially among young teens, and to raise the level of contraceptive use. Other than abstinence, the best way to prevent pregnancy is to use a contraceptive, and the best way to prevent sexually transmitted diseases is to use a barrier form of contraception. Meeting this challenge will take moral clarity, social honesty and political courage - three commodities in short supply these days.