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In light of the continued decline in pregnancy and childbearing among adolescents in the United States subsequent to the first edition of this book, what is the need for a new edition at this time? Have we not obviated the need to revisit what apparently has been a successful effort across public and private sectors, communities, programs, and policies to address teen pregnancy? What more, or different, is there to say about teen pregnancy prevention?

There has been success in reducing rates of pregnancy and childbearing across most demographic categories of teens. This success is notable among even high-risk teens such as low-income African American youth. Although it is difficult to know which factors account for precisely how much of the widespread decline, there are some obvious, if tentative, answers. Some of the decline is attributable to medical advances in contraception; some to changes in behavior of adolescents in response to various forces in their social and cultural environments. It is certain, however, that many factors exert influence on the complex behaviors leading to early pregnancy and parenthood and have contributed to the positive trends between 1991 and 2005.

First, many pregnancies among teenagers are being prevented by effective contraception. Over time, sexually active teenagers have increased their regular use of birth control. In addition, the advent and availability of long-lasting methods of contraception that do not depend on planned use at each time of sexual intercourse or skills to use them contribute to contraceptive success. Second, there appears to be some rising conservatism in sexual activity among some teens. Studies of large, nationally representative surveys find that the age at which adolescents, both boys and girls, begin to have sex has risen slightly and that boys are reporting engaging in less sexual activity. Delaying the age of sexual initiation and fewer
occasions of intercourse that might be unprotected, of course, reduce the overall risk for conceiving as a teenager outside of marriage.

It is reasonable to assume that some of the reasons for these positive changes in sexual behavior are found in the proliferation of prevention programs across the country and in the vigorous campaigns to raise public awareness mounted by local school districts, communities, states, and national organizations that are supported by public policies and private foundations. Other sources of influence are found in some communities’ religious presence and families’ values. It is also reasonable to assume that no single factor was responsible for the recent decline. Rather, many changes converged to create more caution among some young people when they made choices about their sexual development and behavior.

These successes, however, should not lead us to complacency about the current risks that young people, and those who have not yet reached adolescence, face regarding their sexual choices. There are several reasons for continued, and even heightened, vigilance in our attention to high-risk sexual behavior among teenagers.

Most noteworthy at present is the reversal of the decline in adolescent fertility evident during the past two years of available data. The most recent data show a small increase in 2006. The National Campaign to Prevent Teen and Unplanned Pregnancy examined this disappointing news:

New data for 2006 from the National Center for Health Statistics indicate that the 14-year decline in the U.S. teen birthrate has reversed, and both the number of births to teens and the teen birthrate have risen. Between 2005 and 2006, the teen birthrate rose 3%, from 40.5 to 41.9 births per 1,000 females aged 15–19. The number of births to teens also rose by 20,834, from 414,593 to 435,427. (2008, p. 1)

In fact, this reversal was foreshadowed in the past few years by a slowing of the steep decline in fertility and a slight decrease in young women’s use of birth control. In other words, prior to this shift upward in teen births, there was a plateau in the progress of the previous several years. At this time, we do not know if the latest upswing in adolescent fertility represents a trend backward, or is an anomaly that will be corrected in near future.
Even while adolescent fertility was dropping, the incidence of pregnancy and childbearing among American teens remained and continues to be far greater than other Western and industrial societies. Although economic downturns, such as has occurred recently worldwide, tend to be associated with increases in teenage pregnancy in other countries such as in the United States, the differences in rates of pregnancy between American and European, Canadian and Asian adolescents remain considerable. That is, in spite of an absolute decrease in the proportion of teens who bear children, our relative success in reducing teen pregnancy is modest.

In the context of overall and group-specific declines of pregnancy and childbearing, minority teens from low-income families continue to have first and additional children at significantly higher rates than other teens; and these disadvantaged teens are more likely to have closely spaced additional births. As the population of Hispanics in the United States increases, absolute numbers of pregnancies as well as rates of pregnancy among disadvantaged Hispanic youth remain at worrisome levels. Although fertility fell among black youth, their rates of sexually transmitted infections continue to be very high, and young black men account for a significant proportion of new cases of HIV.

The fact remains that many young people put their physical and emotional health at risk by having unprotected sex. When these risks result in pregnancy and parenthood, as they typically do among the most vulnerable youth, the consequences are, in some respects, more negative than in the past. The recent group of studies in Hoffman and Maynard’s “Kids Having Kids” (2008) estimate the relative contemporary costs of a teen having a child. They find the following consequences of not delaying childbearing past adolescence:

- Children of teen mothers are at higher risk of being of low birth weight, have lower cognitive attainment, have lower academic achievement, and exhibit greater behavioral problems.
- The sons of teen mothers are significantly more likely to be incarcerated for some time.
- The daughters of teen mothers are significantly more likely to become teen mothers themselves.
- Men who father children of teen mothers have diminished lifetime earnings.
Teen mothers are over twice as likely to have a report of child abuse or neglect and to have a child placed in foster care within years of birth.

In addition to the costs borne by teen mothers themselves and their children are continuing high costs to the larger society. These include expenditures responding to poor social and economic outcomes, as well as lost tax revenue from foregone earnings. Hoffman and Maynard estimate the cost to taxpayers to be $7.3 billion per year. To the extent that these high costs could be avoided, the urgency of preventing early pregnancy and parenthood remains a moral and pragmatic imperative.

Based on the most reliable existing research, this second edition retains the same organization and conceptual framework of the first edition: the fundamental dynamics of teens’ sexual lives have not changed much since 2003. However, in response to recent research and lessons from relevant practice, this edition includes the following major changes:

1. A significant body of evaluation research on abstinence-only education is now available and incorporated into discussions of pregnancy prevention approaches. It is likely that political changes accompanying the new Democratic administration will shift public investment away from singular support for abstinence-only education, but decisions about which approaches to use should rest on balanced and objective analysis of available evidence of impact.

2. There is now a separate chapter on secondary prevention of teen pregnancy. Although the empirical base remains frustratingly weak as a guide to practice, the most current findings are included.

3. There is more attention paid to sexually transmitted infections throughout. Because the risks of HIV/AIDS face more young people, it is increasingly important to include sexually transmitted infection (STI) prevention as prevention goals. Thus, there is more emphasis on reducing high-risk sexual behavior as a broad perspective.

4. Findings from previous research have been updated to confirm or replace earlier conclusions throughout.

5. Policies have been updated to reflect the current status as of the time of publication.
The message remains the same: the lives of adolescents are so complex, in some ways ever more so, that our collective efforts to help them reach adulthood safely must likewise be complex and be targeted according to the sources of such complexity and diversity. Success in this endeavor is costly not only in material but perhaps even more in human resources. However, it is those human resources in the form of attention, time, and contact with young people that will make the difference in their lives and, ultimately, in the quality of all our lives.
I want to thank Susan Brower and Adair Gindar for their assistance in gathering current research findings. Katie Matheson went above and beyond reasonable expectations of a graduate assistant in each aspect of her contributions to this second edition. I am especially grateful to Candice Morgan, who provided not only dedicated assistance in research but also served as a thoughtfully critical sounding board. Finally, I want to thank Jennifer Perillo for her enthusiastic support and Brian O’Connor for his patient and ongoing help completing this work.
Teenage pregnancy and parenthood are by no means new occurrences in the United States. However, in the past 50 years the social and economic contexts in which unmarried young people become sexually active, conceive, make decisions about pregnancy resolution, and become parents have changed dramatically. Such changes lead us today to regard these behaviors and their consequences among adolescents as sufficiently serious social problems to require intensive and formal public intervention.

During the last several decades, significant attention and resources were directed toward preventing pregnancy among teenagers with some positive effect (Brindis, 2006). Since the early 1990s (see Figure 1.1), pregnancy and childbearing among adolescents have declined by about one third. The birthrate among adolescents fell from 61.8 per 1,000 girls in 1991 to 40.4
in 2005, which is the lowest recorded rate in 65 years. Though the overall decrease in adolescent fertility is unambiguously good news, the positive trend halted in 2006, when the rates of childbearing among American teenagers increased for the first time since before 1991. Recent information shows that the birthrate for U.S. teenagers, age 15–19 years, rose 3% to 41.9 births per 1,000 girls between 2005 and 2006, and then rose again by 1% in 2007. The birthrate for teenagers age 15–17

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**Teen Birth Rates**

Births per 1,000 women in each age group

- Age 18-19: 73 (up 4%)
- Age 15-19: 41.9 (up 3%)
- Age 15-17: 22 (up 3%)

Source: Centers For Disease Control And Prevention
Chapter 1: Dimensions of Adolescent Sexual Activity

years rose 3% to 22.0 per 1,000 in 2006, and 1% more to 22.2 per 1,000 in 2007. The birthrate for teenagers age 18–19 years increased 4% to 73.0 per 1,000 in 2006 and rose another 1% in 2007 to 73.9 per 1,000 girls. The youngest teenagers, age 10–14 years, were the only age group younger than 20 years whose birthrate did not increase in 2006 and 2007 (Martin et al., 2009; Hamilton, et al., 2009).

As adolescent fertility continued to decline after 1991, rates of marriage among childbearing teens also fell unabated (Ventura, 2008). The rise in childbearing outside of marriage is a crucial aspect of how the “problem” of teen pregnancy has changed over time. The individual and social costs of teen pregnancy and childbearing increasingly result from disadvantaged unmarried young women choosing to keep and raise their children, often with compromised means for supporting and nurturing them.

An examination of fertility patterns among young women over time shows that as rates fall, they also can—and do—rise. In addition, teen pregnancy and childbearing in the United States remain the highest among industrialized western countries (Figure 1.2).

In light of recent reversal of progress, continued high rates relative to other industrialized nations, and an estimated annual cost related to teen fertility of about $9.1 billion to American society, we must not be complacent about having finally solved the problems of early pregnancy and parenthood (Hoffman, 2006). This caveat is especially important because no one is certain precisely what caused the welcome changes in youths’ behavior between 1991 and 2005, or what accounts for the reversal in the trend. It is extremely difficult to pinpoint exactly how much any one factor contributes to changes in such complex behaviors. Probably, the confluence of several intersecting trends in our society influenced rates of teenage pregnancy and childbearing downward and then upward again. There are, however, some identifiable correlates and plausible factors.

The immediate causes of the decline in rates of teen pregnancy and childbearing were the lower levels of sexual activity among adolescents coupled with greater use of effective contraceptives by those having sexual intercourse. These shifts were likely caused by youths having greater awareness of and concern over the dangers of contracting HIV/AIDS and other sexually transmitted infections (STIs), a generally
more cautious attitude toward sexual activity among young people, a better economy, aggressive public service media campaigns, and myriad prevention programs ranging from sex education in public schools to comprehensive community-based programs that proliferated nationwide. Some observers believe that these factors and others may have created more socially conservative norms regarding sexual activity among adolescents (Sawhill & Hutchins, 2000).

It is too soon to know the meaning of the recent plateau and then rise in adolescent pregnancy and childbearing. It will be necessary to watch fertility patterns closely to determine whether increased fertility is simply an anomaly that will
be reversed in the near future or is the beginning of a trend toward higher levels. It appears that rising levels of sexual activity among adolescents, coupled with small declines in contraceptive use by sexually active high school females are contributing to the upward change in fertility (Moore, 2008). What accounts for the current shifts? Just as a strong economy may indirectly contribute to decreased adolescent fertility, the present weak economy may be pushing adolescents’ fertility upward. For example, the sharp spike in childbearing among high school students in Gloucester, MA that caused an international flurry of media attention based on rumors of a “pregnancy pact” in 2008 occurred in the context of a depressed local economy. One report attributes increases in teens’ fertility to a loss of momentum in prevention efforts, so-called prevention fatigue (Moore, 2008). It may also be that the deeper cultural characteristics of American society that have contributed to relatively high levels of adolescents engaging in unprotected sex create a barrier to further significant reduction in fertility rates. That is, there may be a “floor” beneath which adolescents’ fertility rates will not easily drop.

Despite the challenge of pinpointing the exact contribution of any one factor, it is clear that behind the notable decrease and then recent increase in fertility and the continuing high rate of out-of-wedlock childbearing among teenagers lay several distinct but intertwined trends. To better understand the current patterns, help sustain the positive ones, and ameliorate the more worrisome ones, it is important to examine in greater detail the fertility-related patterns of adolescents and how their context and social meanings have changed over time.

**Historical Background**

The definition of teenage pregnancy and childbearing as social problems per se is relatively new. The scant historical evidence suggests that young people were sexually active in earlier times, but neither sex among teenagers nor a resulting pregnancy were regarded as special problems related to their age. Rather, the history of adolescent pregnancy and childbearing as social problems in the United States is properly understood as the history of out-of-wedlock childbearing. That is, it has been primarily the meaning we attach to
nonmarital sex and childbearing and their changing consequences rather than the age at which young people engage in sexual relations that has most influenced our response to teenage pregnancy.

It is not possible to determine directly historical patterns of sexual activity and conception among adolescents. Until fairly recently, most women of any age who became pregnant out of wedlock got married. Therefore, a reasonable proxy for premarital sexual activity is the incidence of premarital pregnancies, determined by measuring the time between marriage and the birth of a first child to a woman. There have been wide fluctuations in the incidence of premarital conception over the past few hundred years in the United States and Europe. The seminal research of Smith and Hindus (1975) found a range in premarital conceptions in the United States over time, from under 10% of first births in the 17th century to a high of nearly 30% in the late 18th century.

While premarital sex apparently was common in England during the 15th and 16th centuries, it declined in early Colonial America under the Puritan influence (Vinovskis, 1988). Contrary to the popular characterization of the New England Puritans as discouraging the expression of sexuality, they believed that it was an important aspect of married relations:

\[ \ldots \text{the Puritan attitude toward sex, though directed by a belief in absolute God-given moral values, never neglected human nature. The rules of conduct which the Puritans regarded as divinely ordained had been formulated for men, not for angels and not for beasts. God had created mankind in two sexes; He had ordained marriage as desirable for all, and sexual intercourse as essential to marriage. On the other hand, He had forbidden sexual intercourse outside of marriage. (Morgan, 1983, p. 319)} \]

These expectations were reinforced by publicly punishing offenders and stringently enforcing paternal support of all offspring.

As sexual intimacy became more accepted as part of courting behavior during the 1700s, premarital pregnancies increased. By the end of the 18th century, social sanctions against premarital sex diminished even more, with a corresponding rise in premarital conception. In the second half of
the 1700s, upward of one third of pregnancies were conceived before marriage. “This increase in premarital pregnancy paralleled a steady, visible erosion of church and civil opposition to premarital sexual activity. Across New England the number of civil prosecutions for fornication declined, as did parents’ ability to persuade their children to marry partners of the parents’ choosing. Without opposition from the church, civil authorities and community, sexual intimacy became a normal part of most courtships” (Harari & Vinovskis, 1993, p. 27).

One of the continuing debates in the history of nonmarital sexual behavior in the United States is why there was a subsequently dramatic decline of premarital conceptions in the mid-19th century. Vinovskis suggests that, unlike the reliance on public censure during early colonial times, in the 1800s “reformers devoted more of their efforts to instilling the values of self-control and self-discipline” (Vinovskis, 1988, p. 15). Smith and Hindus (1975) locate the heightened moral conservatism in a “new social matrix” (p. 550). This matrix was characterized by greater independence for youth at earlier ages, the economic shift from the apprentice to wage labor system, greater involvement of youth in the church, including wider participation by members of more sexually permissive classes who consequently were influenced by religious opposition to premarital sex. Smith and Hindus contend that “women also became more active and influential in church affairs and reinforced norms of nonmarital sexual abstinence” (p. 551).

“Social pressure against premarital sexual activity was not directed specifically at adolescents, despite the appearance during the 19th century of medical writings that warned of the particularly harmful effect of premarital sexual activity, including masturbation, on youthful vigor” (Harari & Vinovskis, 1993, p. 28). In general, until well into the 20th century, little attention was paid to nonmarital sexual activity among adolescents as distinct from that of any adults outside of marriage. There are several reasons for this lack of focus on teenagers. One common explanation is that in earlier times, adolescence was not defined as a discrete social phase of development. Historians of the family continue to debate to what degree Americans in the past made sharp distinctions among older children, adolescents, and adults in terms of their normative roles and expected behaviors (Demos & Boocock, 1978). Juster
and Vinovskis suggest that, “it appears that in the seventeenth, eighteenth, and nineteenth century contemporaries only loosely defined the teenage years and based their observations more on economic and social status rather than chronological age” (Vinovskis, 1987, p. 206). That is, individuals’ developmental maturity regarding sexuality, marriage, and parenthood were viewed less in terms of years and more in regard to their ability to fulfill adult roles.

Another reason for the absence of explicit attention to adolescents’ sexual activity is that the vast majority of non-marital conceptions were legitimated by marriage. Of course, unmarried young women did become pregnant, but as long as marriage occurred subsequently and provided for the economic support of the young mother and child, there were few negative consequences of early pregnancy. In addition, by the mid-1800s, both boys and girls usually had completed their education at the age of 15 or 16, so pregnancy did not endanger an adolescent’s educational attainment as it does today.

Likewise, early marriage was not regarded as especially detrimental to women’s well-being, though it was not encouraged. In Colonial America, women generally did not marry until their early 20s, the average age of marriage rising to 24 by the mid-1800s. As most women did not work for wages outside of the home, young motherhood and marriage did not derail their potential for individual economic achievement. Since divorce was relatively uncommon until recent decades, teenage pregnancy also was not associated with subsequent marital dissolution (Harari & Vinovskis, 1993). Consequently, “Although parents and community leaders discouraged pre-marital sexual activity and adolescent marriage and child-bearing, these became disastrous only if the young couple could not support themselves and their child” (Harari & Vinovskis, 1993, p. 29).

The cyclical pattern of premarital conceptions continued as rates rose dramatically over the second half of the 19th century, dropped again precipitously at the turn of the 20th century, and then rose for some years. The pioneering work of Alfred Kinsey during the 1940s and 1950s provides more direct information about sexual activity among young women during the first half of the 20th century. Despite the limitations of this data based on a fairly homogeneous sample of white and middle-class Americans, the changes in sexual behavior over time that he documented give an
important perspective on broader changes in society. Kinsey compared patterns of premarital petting and intercourse among women born before and after 1900. He found that younger women had more sexual experience, including petting and intercourse, at earlier ages than did those women born before 1900. For example, among women who were not married by the age of 25, 14% of the “older generation” had had sexual intercourse compared to 36% of women born after 1900 (Harari & Vinovskis, 1993).

As in earlier times, nonmarital sexual relations during the early 1900s tended to occur between women and their fiancés as part of courtship leading to marriage. However, important shifts were occurring in relations within the family and among young people that resulted in less parental control of teenagers’ sexual activities. On the one hand, there was more acceptance of young women having sexual experience outside of marriage and more openness about sexuality. By the 1920s, unchaperoned dating became more common. Contributing to increasing autonomy for youth, “...social workers and psychologists now encouraged parents to allow children more freedom from interference and free time to spend with their peers. They also instructed parents to be emotionally expressive toward their children. The new ‘compassionate family’ was small and placed increased importance on love and companionship between spouses and between parents and their children” (Harari & Vinovskis, 1993, p. 31). This pattern became part of the increasing separation of sex from the expectation of marriage. While in the past, some young people who were not married certainly engaged in sexual intercourse, generally it preceded marriage, by design or necessity.

On the other hand, more young women became vulnerable to the unintended consequences of the loosening of traditional gender-based double standards for sexual activity. Despite liberalization of norms regarding nonmarital sexual activity, Kinsey observed that young women did not have ready sources of information about sexuality that would help protect them from unwanted pregnancy. He “noted the absence of socialized roles for the mother, the family, the church, or the school to play in helping girls prepare for sexual relations. Instead, petting itself gave girls their ‘first real understanding of heterosexual experience’” (Harari & Vinovskis, 1993, p. 32).
The Depression brought a steep decline in birthrates to adolescents. However, after World War II rates climbed again significantly and continued upward through the 1950s: “the highest rates of teenage births of the 20th century occurred in 1957, at 97.3 births per 1,000 girls aged 15–19.” Birthrates fell steadily during the 1960s, taking a slight upward swing during the last couple years of the decade. It was at this time that teenage pregnancy for the first time became the subject of a focused and growing body of research and of serious consideration in the arena of public policy.

Although the actual rates of pregnancy and childbearing among adolescents have been consistently lower than in 1957, the dramatic changes in our society, since the 1950s, have profoundly altered the consequences of teenagers becoming sexually active and pregnant. As recently as a few decades ago, early sexual intercourse might simply hasten what was an expected and normative outcome for the majority of young women, marriage and motherhood. Over the last 50 years, however, as better methods of birth control have helped disconnect sex from the risk of pregnancy, sex and increasingly childbearing have also been disconnected from marriage. This severing of sex and procreation from marriage is part of significant recent behavioral and biological changes among adolescents as among older women; currently, more than one third of all children are born to unmarried mothers in the United States. Nevertheless, fertility trends among younger resulted in the intense public outcry over what some have named an “epidemic” of adolescent pregnancy. Next, we will examine more recent trends in sexual and reproductive choices in terms of their broad demographic variables.

**Recent Trends in Adolescent Sexuality and Fertility**

**Age of Puberty**

An adolescent’s risk of conceiving results from both physiological and behavioral characteristics (Dunbar, Sheeder, Lezotte, Dabelea, & Stevens-Simon, 2006). To become pregnant, a young woman must be both sexually active and
biologically mature enough to be fertile. The average age of sexual maturity among girls—the onset of menarche—has been declining steadily over the past 200 years (Bellis, Downing, & Ashton, 2006; Herman–Giddens, Kaplowitz, & Wasserman, 2004). Sun, Schubert, Liang, Roche, Kulin, & Lee, 2005). While there is no complete agreement among scientists about the magnitude of such change, some writers estimate the decrease in age to be as rapid as 3–4 months every decade (Zabin & Hayward, 1993; Sun, Schubert, Liang, Roche, Kulin, & Lee, et al, 2005; Herman-Giddens, Kaplowitz, & Wasserman, 2004). Today, the median age of menarche in the United States is 12.6 years. One significant implication of change in the age of menarche is that earlier physical maturation combined with later marriage, the median age for women being 25.3, and greater sexual activity result in more young women facing a longer period of risk of pregnancy outside of marriage during adolescence than teens did in the past.

There is a complex relationship between menarche, physiological capacity to conceive, and sexual activity that is not well understood. It is widely accepted that better nutrition and higher body weight contribute to the earlier onset of menarche today. Selected other factors hypothesized to account for earlier sexual development include greater consumption of hormone-laden cow’s milk concomitant with a decline in breastfeeding by infants, greater environmental exposure to estrogens and endocrines, and older maternal age at childbirth (Zabin & Hayward, 1993).

There continues to be controversy over the nature of differences by race in the age of menarche (Chumlea, Schubert, Roche, Kulin, Lee, Himes and Sun, 2003; Wu, Mendola, & Buck, 2002; Anderson, Gerard, Dallal, & Must, 2003). Some researchers have found that African American girls develop secondary sexual characteristics (such as breasts and pubic hair) earlier than white girls. It appears, however, that social and economic elements are probably the major mediating factors in these small observed differences, and such interracial differences are quite minor when compared with differences between women in the United States and in less affluent nations (e.g., in Africa).

The start of puberty is marked by many aspects of physiological change that exert differential influences on the
psychosexual development of both boys and girls. Zabin and Hayward (1993) summarize the processes and their social significance:

*Pubertal development is caused by increasing levels of steroidal hormones. In males, all physical and morphological changes, as well as nocturnal emission and other aspects of maturation, are caused by androgens. In females, estrogens are responsible for morphological changes such as breast development and genital maturation, whereas androgens cause hair growth. In both sexes, androgens are responsible for increased sex drive experienced during the adolescent years. The role of estrogens in sexual motivation is as yet uncertain. The decline in mean age of menarche in the modern era means at the very least that all these changes occur at younger ages and that fertility is achieved earlier than before. And when they occur at younger ages, they create a discontinuity between biological maturity, on the one hand, and psychosocial and cognitive development, on the other. We have noted that each of these developmental processes proceeds independently. One effect of earlier physical maturation is to put the young person at greater risk of conception and sexually transmitted diseases before the skills to manage a sexual life are well developed. (p. 31)*

There is not a direct relationship between when any particular young woman or man reaches puberty and how likely he or she is to engage in sex or, if sexually active, to conceive. For individual young people, the interplay between their sociocultural environments and physical and psychological characteristics present various pressures, opportunities, constraints, and imperatives that influence sexual behavior and susceptibility to early pregnancy. At the same time, it is worth noting some general observations about the significance of physiological development as a risk factor for early sexual onset, especially among girls.

The actual age of physical development appears to exert a stronger influence on sexual behavior when teens are younger. This is suggested by findings that by the age of 13, almost 40% of girls who reached menarche at the age of 11 or younger are sexually active, whereas only 10% of girls whose menarche had not occurred by the age of 14 are sexually active (Zabin & Hayward, 1993). Not until the age of 17 does this differential
disappear. At the age of 11, more than half of boys who have had their first wet dream (a significant marker of advancing hormonal development) are sexually active, the differential disappearing by the age of 15. Although the association between reaching physical maturation and sexual onset does not hold throughout the teenage years, the strong relationship in earliest adolescence unfortunately brings particular risk of pregnancy, in part because younger teens do not use contraception well and they are also at higher risk of experiencing sexual coercion.

Despite the association between early physical development and sexual initiation across gender, it appears that boys and girls respond differentially to hormonal changes. The best predictor of boys’ sexual behavior—both coital and noncoital—is hormonal level. For girls, noncoital sexual activity but not intercourse is related to their hormonal levels (Zabin & Hayward, 1993). Whether or not girls engage in intercourse is more dependent on their social environment, the prevailing norms, values, and attitudes about sex. Of course, boys often experience both the intense physical surge and more positive cultural messages about having sex than do girls. Nevertheless, girls’ sexual onset is believed to be more socially than physically influenced, while boys seem to be responding to the intensity of dramatic hormonal change.

Sexual Initiation and Activity

It is difficult to make meaningfully precise comparisons of teens’ sexual activity across time because sources of data often include different age groups, samples, and even definitions of behavior. However, it is certainly possible to chart trends and, in recent years, more narrowly defined categories of behavior by age (Whitbeck, Yoder, Hoyt, & Conger, 1999). We find that during the mid-to-late 1950s, fewer than 10% of teenage girls had had intercourse by the age of 16. Between 1971 and 1979, nationwide, “the percent of sexually active girls aged 15–19 rose significantly from 28%–46%” (Hayes, 1987, p. 40). From 1979 to 1982, there was a small decrease, followed by a steady rise over the 1980s (Zabin & Hayward, 1993). In the late 1980s, the proportion had risen to 21%; and by the 1990s, over 50% of teenage girls had had intercourse (Singh & Darroch, 1999). By 1994, the rates had risen to the modern peak of 56% among girls and to 73% among boys (The Alan Guttmacher Institute, 1999).
As the century closed, this trend reversed downward; in 1999, one half of all 9th to 12th grade students reported having had sexual intercourse, with boys only slightly more likely than girls to have become sexually active (Kaiser Family Foundation, 2000). Based on nationally representative data (rather than a sample of high school students), Hoffman and Maynard (2008) report that the percent of never-married girls who had ever had sexual intercourse before the age of 19 fell from 77% in 1988 to 70% in 1995 and remained at 70% in 2002; those girls reporting ever having intercourse by the age of 17 rose from 38% in 1988 to 47% in 1996 and fell to 43% in 2002. Boys in the same sample report even more marked changes in rates of ever having had intercourse by the age of 19: 75% in 1988 to 83% in 1995 falling significantly to 39% in 2002. Those boys reporting sexual initiation by the age of 17 remained at 53% between 1988 and 1995, then fell to 39% in 2002.

In sum, after 1995 there was a general rise in the age at first sexual experience and a decline in the proportion of teens becoming sexually active currently, about one half of teenagers report having had sexual intercourse some time (Kirby, 2007; Kaiser Family Foundation, 2008). Rates of adolescents becoming sexually active vary by race and ethnicity: 68% of African American, 51% of nonwhite Hispanic, and 43% of white high school students report ever having had intercourse (Kirby, 2007).

Recent research shows that many adolescents believe that oral sex carries less risk than vaginal intercourse. More than half of boys and girls ages 15–19 report that they had oral sex with someone of the opposite sex (Kaiser Family Foundation, 2008). Nearly a quarter of boys and girls have had oral but not vaginal sex.

At present, the median age of first intercourse among all teenagers is 17.4 for girls and 16.9 for boys (Kaiser Family Foundation, 2008). While historically, African American youth tended to initiate sexual activity earlier than white and Hispanic youth, this gap has narrowed as non-African American teens began to have sex at younger ages. According to the Kaiser Foundation, “The percentage of 9th–12th grade students who had initiated sexual intercourse before the age of 13 has fluctuated in recent years, from 9% in 1955 (the first year data was collected) to 7.2% in 1997. This trend continues with reports of 6% girls and 8% boys initiating sex before the
the age of 14 in 2002” (Kaiser Family Foundation, 2005). The convergence among white, African American, and Hispanic youths in their likelihood of early sexual activity has been one of the most significant changes in sexual behavior in recent years (Christopher, Johnson, & Roosa, 1994; Zabin & Hayward, 1993). Nevertheless, there remain differences by race and ethnicity not only regarding whether young people become sexually active as an adolescent, but also in how early their sexual debut occurs: 16% of African American students, 8% of Latino students, and 4% of white students initiate sex before the age of 13 (Kaiser Family Foundation, 2008).

In addition to differences by race and ethnicity in early initiation of sexual activity, there are differences by socioeconomic status that appear to be independent of race or ethnicity (Santelli, Lowry, Brener, & Robin, 2000). Living in poverty is strongly associated with beginning to be sexually active as an adolescent. The significance of economic status is evident in different patterns of sexual activity by neighborhood of residence:

In neighborhoods (defined here as block groups) with a median family income less than $20,000, 69 percent of teenage females had ever had sexual intercourse; in neighborhoods in which the median family income was between $20,000 and $50,000, 51 percent had ever had intercourse; and in neighborhoods with median family incomes of $50,000 or more, only 37 percent had ever had intercourse. These differences are found for both white and black teenagers. (Ventura, Mosher, Curtin, Abma & Henshaw, 2000, p. 18)

There is also a strong association between higher levels of sexual initiation among teenagers and higher levels of unemployment and receipt of public welfare in neighborhoods. Although the income-related gap is closing, there remains a clear relationship between low socioeconomic status (SES) and early sexual activity.

Age is also strongly related to becoming sexually active: the older the teen, the more likely he or she is to have had intercourse. The 1999 Youth Risk Behavior Survey found that between grades 9 and 12, the percentage of girls who had had sexual intercourse increased from 32.5–65.8; and among the boys, the increase was from 44.5–63.9 (CDC, 2000). A 2006
report suggests that even among teens who do become sexually active, they are waiting longer than in previous decades: 13% of girls and 15% of boys aged 15–19 in 2002 had had sex before the age of 15, compared with 19% and 21%, respectively, in 1995 (Guttmacher Institute, 2006).

Young teens and preteens face special risks when they become sexually active. Developmental characteristics typically associated with their age diminish their abilities to protect themselves against pregnancy and disease. Another critical aspect of their vulnerability has to do with the circumstances of their becoming sexually active. There is disturbing evidence that many girls younger than the age of 15 who are sexually active experienced some degree of coercion the first time they had intercourse. About 18%–24% of girls who began to have sex younger than at the age of 14 say that it was involuntary and 27% characterized their first sexual experience as unwanted (Kirby, 2007; Hoffman & Maynard, 2008). Having sex at a young age with considerably older partners increases the risk that their first sexual experiences are involuntary or unwanted (National Campaign, 2007). In addition to the potential emotional consequences of early sex in unfavorable circumstances, younger teens who experience unwanted sex are at particularly high risk for STIs and pregnancies.

The very question of whether sex is “wanted” is complex for both boys and girls throughout adolescence. Twenty percent of teens feel pressured—11% “a lot” and 26% “some”—about sex and relationships. Over one third of teens aged 13–18 report having done something sexual, or felt pressure to do something sexual that they did not feel ready to do; while almost one in ten 9th- to 12th-grade students report having ever been forced to have sexual intercourse when they did not want to—11% of girls and 5% of boys (Kaiser Family Foundation, 2008). One study found that fully 40% of a sample of urban teenage girls reported having unwanted sex (Blythe et al., 2006). Continuing trends over the past 2 decades, involuntary sex is more common when there is a larger age gap between partners and among Hispanic and non-Hispanic African American youth (Hoffman & Maynard, 2008).

Most sexually active teenage girls, over 59%, have a first sexual partner who is 1–3 years her senior (Guttmacher Institute, 2006). The younger a girl is when she has intercourse
for the first time, the greater the age difference is likely to be between her and her partner (Kaiser Family Foundation, 2000). It is not surprising, then, that upward of two thirds of fathers are estimated to be 4–6 years older than the teen mothers whom they impregnated. This age gap tends to be greater among white than among African American or Hispanic teenage mothers.

Once becoming sexually active, adolescents tend to have intercourse less frequently than do adults and many are regularly abstinent for periods of time. Among girls who are sexually active, less than half report having intercourse in the past year and a little over a third had sex in the past 3 months (Abama, Martinez, Mosher, & Dawson, 2004). In 2007, 35% of all high school students reported that they had sex with one or more people in the past 3 months (The National Campaign to Prevent Teen Pregnancy, 2008). About half of sexually experienced 14-year-old teens have had sex 0–2 times in the past 12 months. Young men (31%) are more likely than young women (24%) to report that they are currently abstinent (Kaiser Family Foundation, 2000). In general, levels of sexual activity increase with age, with older teens reporting having sex more often and having shorter periods of abstinence.

Sexual relationships among adolescents tend to be episodic and of short duration. Thus, it is common for teens to have multiple sexual partners throughout their adolescence, particularly when they initiate sexual activity at an early age. Usually, teens do not have more than one sexual partner at a time; the majority practice serial monogamy. There was a decline among 9th- to 12th-grade students who reported having four or more sexual partners, from 18% in 1995 to 15% in 2007 (Kaiser Family Foundation, 2008).

There are differences by race and gender in adolescents’ patterns of sexual activity and partnering. Twenty-eight percent of non-Hispanic African American students report that they have had 4 or more sexual partners compared to 17% of Hispanic and 12% of white students (The National Campaign to Prevent Teenage Pregnancy, 2008). These differences are accounted for partly by how early teens in each group initiate sexual activity. The greater the number of partners with whom a teen is sexually intimate, whether serially or simultaneously, the higher the teen’s risk of contracting—and passing on—STIs. Consequently, reducing
the number of partners among sexually active teens is an important objective for their own health and those of potential members of their and their partners’ sexual networks.

Contraceptive Use

Although adolescents’ rates of pregnancy rose overall between 1970 and 1990, their more effective use of birth control helped minimize the increase and continues to mitigate the impact of high levels of sexual activity on pregnancy rates. That is, without a concomitant increase in contraception, the rate of teenage pregnancies would have been and remained higher. One study estimates that over one million pregnancies were avoided by teenagers using birth control (Kahn, Brindis, & Glei, 1999; Glei, 1999). Today, most sexually active teens report that they use birth control at least sometimes. Nevertheless, despite the rise in teens’ use of birth control, studies documenting this increase do not always reveal the complexity of measuring actual pattern of use. The challenge in capturing accurate information likely results in underestimating how inconsistent teenagers are in their real use of birth control over time.

Between the early 80s and mid-90s, the use of contraception by sexually active teens declined. The percent of teens who used contraception both the first time and most recent time they had sex fell, then subsequently rose. Current research finds that about 74% of girls used birth control the first time they had sex and 83% during the most recent sexual encounter. Boys report even higher levels of contraception, 82% the first time they had sex and 90% the last time they had intercourse (Kirby, 2007).

Overall rates of contraceptive use vary widely among sexually active teens according to their race and ethnicity. Hispanic teens are less likely than African American or white teens to use birth control at first intercourse or any time thereafter. Among Hispanic youth, 73% of boys and 66% of girls report using a method of contraception at first intercourse, in contrast to 85% of white boys and 78% of white girls and 86% of African American boys and 71% of African American girls (National Campaign to Prevent Pregnancy, 2006).

In recent years, sexually active teens have changed not only their propensity to use contraception but the methods they choose. The most commonly used method of birth
control among teens is the condom. Condom use by 15- to 19-year-old teens at first intercourse rose from 69% to 71% between 1995 and 2002 (Guttmacher Institute, 2008). In 2007, 62% of sexually active high school students used a condom the last time they had sex (Kaiser Family Foundation, 2008). This includes 69% of African American, 63% of white, and 58% of Hispanic students. Although condoms have about a 97% success rate when used properly, the American Academy of Family Physicians estimates that “typical” use of condoms by teenagers results in a 14% failure rate (As-Sanie, Gantt, & Rosenthal, 2004). Nevertheless, even imperfect use of condoms contributes to teens protecting themselves and their partners from pregnancy and STIs.

After condoms, the next most frequently used form of contraception is the pill. About 16% of sexually active high school students report that they or their partner were using an oral contraception at last intercourse (Kaiser Family Foundation, 2008). White students are twice as likely as African Americans or Hispanics to use an oral contraceptive. Oral contraception is extremely effective in preventing pregnancy, with a less than 1% failure rate when used as prescribed (As-Sanie et al., 2004). However, it is important to note that even when a young woman says that she used birth control at last intercourse or that she currently “uses” the birth control pill, it is not uncommon to miss taking her contraceptive pill 1 day and then double up the next day, leaving her unprotected from pregnancy. Some research finds that among 15- to 19-year-old girls relying upon oral contraceptives, only 70% take the pill everyday (National Campaign to Prevent Teen Pregnancy, 2007). Teenagers who recently began to use the pill and those who have already had one unplanned pregnancy are especially inconsistent in their use.

A rising minority of sexually active girls use injectable and other nonoral forms of hormonal birth control, such as Depo-Provera or the contraceptive patch (Dinerman, Wilson, Duggan, & 1995). Like oral contraceptives, these other hormonal methods are over 99% effective when used properly. They have the important advantage over all other types of birth control of requiring relatively infrequent doses. These methods range from the Ortho Evra patch that requires weekly application for 3 out of 4 weeks per month, to the single-rod implant that lasts for 3 years, to intrauterine devices (IUDs) that can remain in place for up to 10 years. Almost 10% of teens used
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1.3

Contraceptive Options for Adolescents


A hormonal contraceptive at last intercourse, but over 20% of teens report that they have ever used one. Introduced in the 1990s, their use has doubled in the past decade and likely will continue to gain popularity in use (see Figure 1.3).

The rising incidence of STIs among adolescents leads most health-related professionals to recommend strongly that teens use dual methods of contraception. Best practice suggests that the best way to guard sexual health is to use hormonal birth control to prevent pregnancy and a condom to prevent an STI. Increasingly, teenage girls appear to be taking greater responsibility for prevention. The percentage of teenage girls using both a condom and
hormonal contraception nearly doubled to between 1995 and 2002 to about 20% (Kaiser Family Foundation, 2008).

The rates of ever having used contraception are fairly similar among African American, white, and Hispanic teens; 97.1%, 98.4%, and 94.3% respectively. However, there are important differences by teens’ race and ethnicity in the kinds of contraception they use. White students are much more likely than African American and Hispanic students to report using birth control pills before they last had sex or at all and also to use withdrawal (National Campaign to Prevent Teenage Pregnancy, 2008; Hoffman & Maynard, 2008). Condom use is high among both African American teens (94.6%) and white teens (95.9%), much less so among Hispanics (82.8%) (Hoffman & Maynard, 2008). This places sexually active Hispanic teens at disproportionately high risk for STIs. Significantly more black and Hispanic teens use injectable contraception than whites. White teens are most likely to use emergency contraception, followed by Hispanic and then African American teens. Overall, about 8% of sexually active adolescents use emergency contraception some time.

Economic status is also associated with different patterns of contraception: among girls who are sexually active, 78% of very poor teenage women, 71% of low income, and 83% of higher income report using birth control regularly (National Campaign to Prevent Teen Pregnancy, 1999). Low-income teenagers are twice as likely as more affluent teenagers to experience a pregnancy that is unplanned even while reportedly using the birth control pill or condom. One study that included estimates of “contraceptive failure rates” of teens reported that, “In general, failure rates were higher for teenagers whose family income was less than 200% of the federally defined poverty level and for those who had never been married” (Kahn et al., 1999).

Probably the most important factor in whether sexually active teenagers use birth control is their age. While younger teens are more likely than older and more sexually experienced teens to use a condom, with its dual protection against pregnancy and STI; they are also less adept and reliable in using birth control each time they have sex. The younger an adolescent is, the less likely he or she is to use contraception or to seek help in avoiding pregnancy. While teenagers generally are less effective at contraception than older women, younger teens are even less so.
Another important influence on contraceptive behavior is the nature of the relationship in which sex occurs. Teens are more likely to use a condom with a casual partner than with a steady romantic partner. However, teens in a steady relationship in general are more inclined to use effective contraception, such as hormonal methods. Recent research highlights the growing consensus that when adolescents are comfortable in a relationship and able to communicate openly about risks of STI and pregnancy with their partner, they are able to negotiate good choices about birth control (Manlove, Ryan, & Franzetta, 2007).

Teenagers who go to a physician or clinic for contraception wait for an average of 11 months after first having sex to do so. However, young teens tend to wait even longer to seek assistance. This long delay is particularly problematic because of the high risk of pregnancy in the early months after onset of sexual activity, a risk that is heightened when teens initiate sex at a younger age. When exposure to pregnancy risk starts early, the overall risk of conceiving is higher. Zabin and Hayward (1993) observe that young teens who are sexually active often appear at clinics for birth control only after they are already pregnant.

Patterns of contraception vary some among teenagers who have already had a child. African American teen mothers are significantly more likely today and more likely than other teens to use very effective contraception such as Depo-Provera or Norplant. Their use of the pill has dropped steadily and dramatically. Greater availability and use of these very effective forms of birth control certainly contributed to the decline in subsequent pregnancies among African American teen mothers over the last decade.

Rates of Adolescent Pregnancy

Between 1991 and 2005, there was a remarkable decline in the rates of pregnancies among all teenagers and among sexually active teenagers. Yet, the most recent evidence indicates that, after a few years of plateau, the trend may be reversing. In 2002, about 75 of every 1,000 girls age 15–19 became pregnant. Despite the overall downward trend in rates of conception, cumulatively, over 30% of adolescent girls still become pregnant at least once before the age of 20 (Kirby, 2007).
The decline in pregnancy rates occurred among adolescents of all ages. Among teens aged 15–17 the rate of pregnancy fell 16% from 80.3 per 1,000 in 1990 to 67.8 in 1996, and then even more dramatically to 42.3 in 2002 (Hoffman & Maynard, 2008). The rate for older teens also dropped, down 12% from 167.2 per 1,000 to 146.4 in 1996, continuing downward to 125.6 in 2002 and then to 119 in 2004 (Ventura, 2000; Hoffman & Maynard, 2008; Kaiser Family Foundation, 2008). Older teens, however, continue to have the highest incidence of pregnancy among all adolescents: about 70% of pregnancies to adolescents occur among 18–19-year olds (Kaiser Family Foundation, 2008).

Rates of teen pregnancy for all races fell, but the overall decline does not reveal the uneven changes by race and ethnicity. The drop was most dramatic among African American teens, about 40% between 1991 and 2000 (Ventura et al., 2000; Hoffman & Maynard, 2008). Pregnancy among Hispanic teens also declined but less so. In 2002, the rate of pregnancy was 48 among white girls age 15–19, 134 among African American girls, and 132 among Hispanic girls per 1,000. The differences by race and ethnicity overall are consistent among older teens ages 18–19: in 2004, pregnancy rates were 79.3 per 1,000 for whites, 202.9 for African Americans, and 210.0 for Hispanics (Ventura et al., 2008).

Another way of viewing the differences by race and ethnicity is in terms of how many teens who had intercourse in the past year became pregnant: one out of three sexually active African Americans and Hispanic teens conceived in a year compared with one out of six white teens. Among sexually active teens, then, rates of conception were 142 for whites, 305 for African Americans, and 291 per 1,000 for Hispanic youth (Ventura et al., 2000). The lower rates of pregnancy among white teens results from their being less sexually active at young ages and more likely to take measures to prevent pregnancy when they do have intercourse (Ventura et al., 2000).

It is clear that recent changes in both sexual and contraceptive behavior have had a positive impact on pregnancy rates among adolescents. The most immediately visible changes include white teens’ greater use of condoms and their postponement of sexual initiation coupled with African Americans teens’ use of injectable and implant birth control.
Sexually Transmitted Infections

Sexually active teenagers face significant risk of contracting STIs. Young people ages 15–24 constitute fully half of all new cases of STI, and every year there are about 4 million new cases of STI among teenagers. The CDC (2008) estimates that about one in four girls ages 14–19, about 3.2 million, is infected with at least one STI. Prevalence varies significantly by race: 48% among African American girls versus 20% among both white and Hispanic girls. In the face of this major threat to teens’ immediate and long-term health, any consideration of the most effective ways to reduce teen pregnancy and childbearing should also include reduction of STI as a corollary objective. Among the many types of STIs, the most common among adolescents are human papillomavirus (HPV), chlamydia, gonorrhea, trichomoniasis, syphilis, and HIV. These STIs vary in modes of transmission, symptoms, and health consequences. The risk of contracting an STI increases with the number of risk factors including socioeconomic status, abuse, exposure to violence, substance use, and depression (Buffardi et. al., 2008).

**Human Papillomavirus (HPV).** Human papillomavirus (HPV) is the most common sexually transmitted virus worldwide, including in the United States. HPV poses serious long-term risks for young women because it is associated with later development of cervical cancer. The prevalence among adolescents is about 25%. HPV can be transmitted either sexually or nonsexually, including by nonpenetrating sexual contact. Risk for contracting HPV is particularly high if girls first have sexual intercourse at a young age, and have multiple sexual partners. Younger girls are at such high risk because cervical tissue changes during puberty support the replication of HPV, thus raising the risk for active infection. High rates of infection and the health risks of HPV lead the American Cancer Society to recommend that all girls age 11–12 be vaccinated against HPV and girls and women age 13–26 receive “catch up” vaccination. This remains an extremely controversial recommendation in many communities, but does highlight the seriousness of the threat to young women’s health.

**Chlamydia.** Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. Among
15–19-year-old teens, rates of chlamydia infection are about 1,600 per 1,000,000. Here is higher incidence among girls (2,862 per 100,000) than among boys (CDC, 2006). African American women have the highest rates of infection, followed by American Indian/Alaska Natives, Hispanic, white, and Asian/Pacific Islanders (CDC, 2006). Untreated, chlamydia can cause damage to a woman’s reproductive organs and result in infertility. However, because symptoms may be mild or absent, young women often are not aware of being infected and so do not seek testing and treatment. Chlamydia is quite effectively treated with injected antibiotics, though reinfection is common.

**Gonorrhea.** Gonorrhea is another curable bacterial STI that occurs commonly among adolescents and young adults, second in prevalence after, and often concurrently with chlamydia. After several years of decreasing incidence, rates of gonorrhea among both boys and girls ages 15–19 increased among all races and ethnic groups except Asians in 2006. Gonorrhea, like chlamydia, is more prevalent among girls than among boys. It is spread by vaginal, oral, or anal sexual contact. Gonorrhea can spread to other parts of the body, (e.g., to the eyes) after touching infected genitals, as well as to infants from an infected mother. Boys typically experience some symptoms when they become infected, but girls less so. Though gonorrhea is very effectively treated with antibiotics, untreated infection among girls can cause pelvic inflammatory disease (PID) sterility, and ectopic pregnancy.

**Trichomoniasis.** Trichomoniasis is another common and readily treatable STI. Caused by the parasite, *Trichomonas vaginalis*, it is the most commonly diagnosed STI among adolescents after HPV. Trichomoniasis is transmitted sexually through penis-to-vagina (or vulva-to-vulva) contact. The most common site of infection for boys is the urethra and for girls the vagina. Girls can contract the disease from an infected partner of either gender, but boys typically contract it only from infected girls.

**Syphilis.** Syphilis, caused by the bacterium *Treponema pallidum*, shares many of the signs and symptoms of other diseases, but over time has a distinct trajectory that, if untreated, carries distinct and serious health risks. Syphilis is contracted
by both boys and girls through direct contact with a syphilis sore, typically during vaginal, anal, or oral sex. These sores occur mainly on the external genitals, vagina, anus, or in the rectum but also can occur on the lips and in the mouth. Syphilis has declined markedly among African American youth but not among white and Hispanic teens. Syphilis develops from the primary phase, marked by a sore or chancre to secondary syphilis, characterized by skin rash and mucous membrane lesions. The final and latent stage of syphilis begins after primary and secondary symptoms disappear. Ultimately, the untreated disease can result in damage to internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints, which can cause death. As with the other sexually transmitted diseases discussed thus far, syphilis can be effectively treated when diagnosed early.

While the STIs most frequently diagnosed among adolescents are curable, there are some exceptions. For example, herpes simplex virus type 2 can be treated to reduce outbreaks of the symptoms, but not actually cured.

Most adolescents who contract a sexually transmitted illness can be successfully treated, thus providing a cure for the immediate disease and the opportunity, through behavioral changes, for prevention of further illness. HIV and AIDS present a far different set of health issues for young people. Although the prevalence of HIV/AIDS among teenagers is fairly low, the number of cases rose between 2001 and 2005 (Kirby, 2007). In 2005, among 13- to 19-year-old teens, there were 6,324 reported cases of AIDS. However, because of the potentially lengthy time between being infected with HIV and onset of AIDS, the best way to gauge current trends is through rates of HIV. Among younger teens, 77% of new HIV cases are among girls, in contrast to older teens, among whom boys are slightly more likely to be newly-infected. Girls are more likely to be infected through heterosexual contact, often with injection drug users, whereas for boys, it is more often male-to-male sexual transmission (Kirby, 2007). In 2003, about three-quarters of new infections were reported among African American youth.

There is a close connection between HIV/AIDS and other STIs that heightens the urgency of diagnosing, treating, and ultimately preventing STIs among young people: “Individuals who are infected with STDs are at least two to five times more likely than uninfected individuals to acquire HIV infection
if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is also infected with another STD, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons” (Wasserheit, 1992). There appear to be two main ways through which susceptibility to getting and passing on HIV increases by having an STI. The first is through genital ulcers that break in the genital lining or skin and create a point of entry for HIV. Second, the inflammation resulting from genital ulcers or nonulcerative STDs, such as chlamydia, gonorrhea, and trichomoniasis, creates a greater concentration of cells in genital secretions that can serve as targets for HIV when they are exposed to semen or other sources of HIV (CDC, 2008). Thus, increasingly the importance of helping adolescents prevent pregnancy must be understood equally as helping them safeguard their health from potentially deadly threats.

Births to Adolescents

After several years of good news, births to teens not only stopped dropping, but they also began rising. In 2005, about 40 of every 1,000 girls between the age of 15 and 19 gave birth (Kirby, 2007). Between 2005 and 2006, birthrates among teens increased from 40.5–41.9 per 1,000 and then rose the next year to 42.5 per 1,000 teens (Hamilton, Martin, & Ventura, 2007; 2009). The rates and their pattern of change differ by race and ethnicity. The birthrates per 1,000 teenagers include: 81.7 among Hispanics, 63.7 among African Americans, 59 among American Indian or Alaska Natives, and 26.6 among whites (Martin, et al., 2009). This disappointing change follows 13 years of decline in rates of adolescent childbearing.

After rates rose between 1986 and 1991, there began a steady drop throughout the 1990s and early part of this decade in the proportion of American teenagers who gave birth. In 1998, the birthrate for all teens was 51.1, 2% lower than in 1997 and 18% lower than in 1991 (Ventura et al., 2000). This reflects the lower level of sexual initiation and activity among young people and better use of birth control.

Comparing birthrates by race and ethnicity (see Figure 1.4), the largest decrease was among African American teens. Between 1991 and 1998, the birthrate for black teens aged
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1.4 Births to Adolescents

Birth Rates (per 1,000) for Females Ages 15 to 19
By Race and Hispanic Origin, Selected Years 1960–2006

LEGEND:
= all races
= Hispanic
= Non-Hispanic Black


15–17 fell 26% from 115.5 to 85.4 (Ventura et al., 2000). This rate is the lowest for African American youths since 1960. The birthrate among Hispanic teens fell 13% between 1994 and 1998 (107.7) (National Campaign to Prevent Teen Pregnancy, 1999) Since 1994, Hispanics have had the highest birthrate among all racial and ethnic groups. However, it is important to make finer cultural distinctions within major ethnic groups. For example, the birthrate for Cuban teens increased 38.3% between 1991 and 1998, but among other major subgroups of Hispanic teens, the birthrates declined (National Campaign to Prevent Teen Pregnancy, 1999). Among Mexican Americans,
the birthrate fell 4.2%; among Puerto Ricans, it fell 27.1%; and the birthrate among teens of “other/unknown” descent fell 18.2% (National Campaign to Prevent Teen Pregnancy, 1999). It is noteworthy that in the context of the last few years’ rise in births to teens, only the rate to Hispanic adolescents declined, by 2%, in 2007 (Hamilton, Martin, & Ventura, 2009). Among other ethnic groups, the greatest increase over the past year was reported for American Indian or Alaska native teenagers, up 7% during 2006–2007 (Hamilton, Martin, & Ventura, 2009).

Rates of second births to teenage mothers also declined significantly between 1991 and 1997. Most dramatic was the decline of 28% in second births to African American teenage mothers from 221 to 181 per 1,000 adolescents (Ventura et al., 2000). Second births to teenage mothers are much greater than the likelihood of a first birth to teens who have not had a baby. In 2001, there were 35 births per 1,000 girls who had not previously had a baby compared with 175 births per 1,000 girls who had previously had one baby (Child Trends, 2003).

Birthrates to girls aged 15–19 also vary considerably across states, ranging from a low of 17.7 in New Hampshire to 63.4 in District of Columbia (CDC, 2008). These differences are in part related to patterns of racial and ethnic composition of each state. Generally, those states with higher proportion of African American and Hispanic teens have higher rates of teen pregnancy and childbearing. However, when comparing teen birthrates by race and ethnicity, it is important to consider the impact of poverty on patterns of early conception and childbearing.

Although birthrates declined consistently across population groups, as well as across almost all states, the overall teen birthrate is still higher than it was in the mid-1980s. In addition, in contrast to the rate of births, the actual number of births to teens in the oldest age group actually increased 3%. This is because there was a 5% increase in the number of teenage girls aged 18–19 in the general population. A broad demographic perspective is crucial in assessing the overall risk and magnitude of early childbearing in our society: even in the face of a lower proportion of youth having children, the total number of births can increase, as is occurring among Hispanic adolescents. Thus, even maintaining stable rates of pregnancy and childbearing may result in a greater number of adolescents having children in coming years, perhaps as much as a 26% increase.
Abortion

Not all teenagers’ pregnancies result in a live birth. About 14% of pregnancies to adolescents end in miscarriage and about 35% are aborted (Neinstein et al., 2009). Abortions to teenagers account for about one quarter of all abortions performed nationwide, with variations by state.

During the years immediately following the legalization of abortion in 1973, abortion rates among women of all ages, including teenagers rose and then remained steady until the early 1980s. From 1988 to 1996, the abortion rate for teenagers fell 33% from 43.5 to 29.2 per 1,000 adolescents (Ventura et al., 2000). From its high, the teen abortion rate decreased by more than half by 2000 (Ventura et al., 2003). In 2004, the abortion rate for teens age 15–19 was 19.8 per 1,000 girls (Kaiser Family Foundation, 2008).

This trend is consistent with changes in attitudes of young men toward abortion. Between 1988 and 1995, approval of abortion by young men decreased significantly (Boggess & Bradner, 2000). The change was greatest among non-Hispanic whites, and coincided with an increase in the self-reported importance of religion, especially among fundamentalist Christian youth, and more conservative attitudes toward premarital sexual intercourse. Young men’s perspectives on abortion are important to consider because the fathers of teens’ babies often strongly influence the outcome of a young woman’s pregnancy. The majority of minors who have abortions—about 61%—do so with at least one parent’s knowledge and that the majority of those parents support their daughter’s decision (Kaiser Family Foundation, 2000).

The abortion rate among all minority youth is considerably higher than among white teenagers. This is mainly the result of their having higher rates of sexual activity and lower use of contraception, thus being more likely to experience an unintended pregnancy. In addition, however, African American teens who are pregnant are more likely than other teens to seek an abortion: in 2004, more than 37% of pregnancies among African American teens ended in abortion, compared to 12% for whites and 19% for Hispanics (CDC, 2008).

Adoption

Although most pregnant adolescents say that they did not intend to become pregnant, most teenagers who carry their
pregnancy to term choose to keep their children (Barth, 1987; Remez, 1992; Resnick, 1984; Dworkin, Harding, & Schreiber, 1993). It is difficult to obtain reliable information about formal adoption rates among teenagers. Some current estimates are that only about 9% of white and 5% of African American adolescent mothers relinquish their children, while other research indicates that less than 4% of all pregnant teens place their children for adoption (Donnelly & Voyandoff, 1991). This trend toward fewer teenagers choosing adoption to resolve an unplanned pregnancy is consistent with the decline among adult women relinquishing infants for adoption.

Young women who release children for adoption tend to be different from other pregnant teens, especially teens who choose to parent (Donnelly & Voyandoff, 1991). Young teens relinquish more often than those older than 18. Those who relinquish are more likely to be white, come from more affluent families, have higher levels of education and perceive more educational and other options besides motherhood, and have positive attitudes toward adoption. There is some evidence that young women who choose adoption are also more apt to have been sexually abused.

Births to Unmarried Adolescents

When the rate of teens bearing children was twice as high in 1957 as it is today, almost all births were legitimated by marriage—shotgun or otherwise. Today, a small minority of pregnant teens marry. Although the birthrates to teens overall and to unmarried teens have been dropping steadily in recent years, the proportion of teens who give birth and are unmarried continues to rise. This trend is part of a widespread shift in social norms regarding out-of-wedlock childbearing: today, reaching an historic high, about 40% of all births in the United States are to unmarried women, including approximately 22% among white, 43% among Hispanic, and 68% among African American women (Hamilton, Martin, & Ventura, 2009). Another way of indicating the tectonic shifts in norms of single motherhood is that in 1970 teens comprised half of all births to unmarried women. In 7 only about 23% of all births to single mothers were to adolescents (Hamilton, Martin, & Ventura, 2009).
Mirroring the much greater acceptance of childbearing outside of marriage and single motherhood throughout American society, the likelihood that a teenager who gives birth is married has decreased dramatically over the last 3 decades (see Figure 1.5). Nationwide, in 2004 (see Figure 1.6), over 80% of births to teens were outside of marriage (Hoffman & Maynard, 2008).

African American teenagers are least likely to marry to legitimize a birth—less than 4%. Childbearing Hispanic teenagers are still more likely than either African American or white teens to be married, about 23%, but their rates of out-of-wedlock parenthood are rising (Hoffman & Maynard, 2008). Of all major racial and ethnic groups, Asian American teenagers are least likely to bear a child outside of marriage. A notable exception to the low-birth rates among Asian American teenagers, Hmong youth have relatively high rates of fertility but also are more likely than other teens to marry (Farber, 1999).
Summary

The second half of the last and first decade of this century have seen a profound transformation in patterns of family formation that are reflected in the contemporary sexual and reproductive behaviors of America’s young people. The peak in the rates of pregnancy among adolescents occurred in the late 1950s. However, during the subsequent decades, changing social mores and a highly sexualized and individualistic youth culture resulted in many diverse groups of young men and women being vulnerable to early pregnancy and childbearing outside of marriage. What in earlier times more often led to the formation of marital families increasingly results in single-parent, usually single-mother, families with all of the associated economic, social and psychological vulnerability experienced by both parents and children.

It is a cause of optimism that the rapidly accelerating trend toward adolescents having earlier sexual initiation
and the high rates of pregnancies and births that we saw through the 1980s slowed, even declined somewhat, in certain subgroups of youths. In addition, more young men and women have greater access to and better ability to use various effective methods of birth control when they do have sexual intercourse.

At the same time, fertility rates have risen again. In addition, the social context in which ever younger boys and girls become sexually active and place themselves at risk of pregnancy and STIs creates ever higher costs for unplanned and youthful parenthood. Decreasing public interest in supporting single-parent families creates higher expectations for young women to work outside of the home. As research continues to discover more worrisome information about the short- and long-term negative consequences of growing up in a mother-only home, our sense of urgency in preventing the formation of new adolescent families should be growing. This is particularly true for those populations of youths that are already at greatest risk for the worst individual outcomes by virtue of their race or ethnicity, their class, and their community and family environments. In the next two chapters, we examine major theories of adolescent pregnancy and parenthood, and why the risks of early sexually activity, pregnancy, and parenthood vary so among youths.