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COMBATTING ILLEGITIMACY AND COUNSELING TEEN ABSTINENCE: A KEY COMPONENT OF WELFARE REFORM

INTRODUCTION

Soaring rates of illegitimacy are threatening America's social fabric. But Members of Congress and state officials, as they wrestle with the problems of reforming America's welfare system, can design a functional public policy to combat adolescent pregnancy and illegitimate births. This policy should be based on personal responsibility, including sexual abstinence.

For the last quarter century, government has pursued a pragmatic "contraceptive approach" to adolescent pregnancy. This approach has been a costly failure because it generally ignores basic realities of culture and developmental psychology. The "abstinence approach," on the other hand, successfully incorporates the basic cultural and psychological realities of the transition to adulthood. By inculcating individual "resistance skills," abstinence becomes more firmly established the more widely it is applied, which in turn has a beneficial effect on social norms.

In a healthy society, individuals are motivated by hope for the future rather than instant gratification, and rely on social skills rather than technology to overcome interpersonal problems. These are precisely the qualities abstinence promotes. Without personal responsibility, which is recognized throughout society as the basic requirement for life achievement, attempts to reform the current dysfunctional system can have only minor, inconsequential results.

Taxpayers' money should be used only for social programs that work. If state officials are going to administer these programs, with funding transferred in block grants to the states, they should focus on attacking illegitimacy directly. This includes using funds

for abstinence counseling, not merely contraception, and for adoption rather than abortion.[1] While plans advanced by the Clinton Administration and the Senate Republican leadership ignore abstinence education as a way to help control illegitimacy, the proposal by Senators Lauch Faircloth (R-NC), Phil Gramm (R-TX), and John Ashcroft (R-MO) earmarks $200 million for such education under the Maternal and Child Health Services Block Grant.[2]

Young people who want to avoid poverty and dependency can do three things: complete high-school; get a job, even a low-paying one; and have children only within marriage. For several decades, this formula has been ignored in the development of public policy as increasing numbers of unmarried teenage mothers have slipped out of school, out of the economic mainstream, and into dependence. Many remain dependent for long periods of time in spite of attempts by policymakers to reform this key aspect of welfare.[3]

Responding to growing public concern, President Clinton and many Members of Congress have attempted to focus welfare reform efforts on the illegitimacy crisis. Unfortunately, although official Washington's rhetoric has been stirring, many of these proposals are unchanged from the existing failed strategy.

While no one can dispute the health advantages of abstinence, and while most people would admit that it is the socially, developmentally, and psychologically appropriate course for an adolescent, there are many who assert that abstinence is impossible for an adolescent. This assertion is groundless. For decades, if not centuries, sexual abstinence was expected of unmarried individuals in Western society. According to the National Survey of Family Growth (NSFG), abstinence was the norm among unmarried American teenage girls at least until 1982.[4] The best of the recent surveys of high school age youth (young people 14-17 years old) was conducted as part of the National Health Interview Survey of 1992. This survey showed that 56.6 percent of adolescents were virgins.[5] A series of surveys conducted over the last 25 years by *Who's Who Among American High-school Students* shows that only one in four top students is sexually active. This suggests that abstinence is not only possible, but associated with high levels of personal achievement.[6]

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1 For an excellent discussion of the role of adoption in the welfare debate, see Patrick F. Fagan, "Why Serious Welfare Reform Must Include Serious Adoption Reform," Heritage Foundation *Backgrounder* No. 1045, July 27, 1995.

2 The Faircloth-Gramm-Ashcroft proposal focuses abstinence education on the social, psychological, and health gains of abstaining from sexual activity while unmarried; backs abstinence from sexual activity outside of marriage as the "expected standard" for school-age children; teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy and sexually transmitted diseases; teaches that marriage is the "expected standard" of human sexual activity; teaches that sexual activity outside of marriage is likely to have "harmful psychological and physical effects"; and teaches that bearing children out of wedlock is likely to have "harmful consequences" for the child, his parents, and society.

3 The Urban Institute estimates that slightly over half of those currently on welfare will become long-term dependents (on the welfare rolls for 5 years or more). The length of time unmarried adolescent mothers typically spend as AFDC recipients is widely recognized as twice that spent by recently divorced mothers, for whom the program generally is truly transitional.

4 In the 1982 NSFG, virgins were a narrow majority of unmarried teens. By 1988, non-virgins were a narrow majority. (Earlier cycles show the preponderance of virgins much more strikingly.)

5 *Morbidity and Mortality Weekly Report*, U.S. Department of Health and Human Services, Vol. 43, No. 13 (April 8, 1994).

6 *Who's Who Among American High School Students* Paul Krouse, Publisher (Lake Forest, Ill.: Educational Communications, Inc., 1995).

UNINTENDED CONSEQUENCES

Recognizing the struggles and special needs of single parents, American public policy throughout this century has experimented with various forms of aid. Aid to Families with Dependent Children (AFDC) began as Aid to Dependent Children (ADC) in the 1935 Social Security Act but was modeled on the cash-grant "Mothers' Aid" programs that various states had developed several decades earlier. As these modest, supervised programs expanded due to legislation, regulations, and court decisions, there was growing concern that for many, welfare dependency was becoming a permanent status, not a transitional phase. A cultural shift accompanied this program expansion: Where previously there was a social and often legal presumption against the ability of an unmarried teenager to raise a child, the perception began to arise that giving birth outside marriage was not only socially acceptable, but also without consequence to children born and raised in non-formed families.[7]

The family is responsible for the basic socialization of children, and when the family breaks down or is never fully formed, children are most affected. They suffer in health, education, and emotional development.[8] This is well-documented, but a few facts help to suggest the human impact. White girls growing up fatherless are two and a half times more likely to have a child out of wedlock. For a fatherless white child, the chances of finishing high school drop 40 percent; for a fatherless black child, they drop 70 percent. Yet, as welfare recipients increased in number, in some neighborhoods, children dependent not on a father and mother but on the state became the norm rather than the exception. In these areas, welfare programs are the dominant legal economic force, and recipiency is common among young women.

Recognizing that in many communities there is a cycle of poverty, public policy should be concerned about how dependency is transmitted from one generation to the next. Welfare traditionally has focused on adult female recipients; however, their children also merit increased concern. This is especially true for boys growing up without the guidance of fathers in neighborhoods where few boys have the example of fathers who support the family. They are raised by peers on the streets, without social norms, achievable goals, or hope. In the worst cases, their lives are marked by violence and crime, and end early. This is just one more area in which a program meant to do good spawns social disorganization and cultural turmoil.[9]

Senator Daniel Patrick Moynihan (D-NY) relates a conversation between a social scientist who was visiting a poor neighborhood in Chicago and an adolescent living there. The visitor asked the child what she would do when she grew up and was told that she "would draw." Sensing some hope in the bleak surroundings, the visitor asked a follow-

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7 For a discussion of the evolution of this system, see George W. Liebmann, "Addressing Illegitimacy: The Root of Real Welfare Reform," Heritage Foundation *Backgrounder* No. 1032, April 6, 1995.

8 For a solid review of the social consequences of illegitimacy, see Patrick F. Fagan, "Rising Illegitimacy: America's Social Catastrophe," Heritage Foundation *F.Y.I.* No. 19, June 29, 1994.

9 For an excellent and comprehensive discussion of the relationship between crime and family breakdown, see Patrick F. Fagan, "The Root Causes of Violent Crime: The Breakdown of Marriage, Family, and Community," Heritage Foundation *Backgrounder* No. 1026, March 17, 1995.

up question: "What would you draw?" The girl's answer: "Welfare, like my mother."[10] Although the fate of this particular child is not known, examples abound of the subtle yet pervasive draw of welfare in urban areas.

The United States is not alone in its perplexing re-examination of the social effects of such relief programs. A similar review is underway in Britain, where the out-of-wedlock birthrate has risen from 5 percent in 1960 to the current 30 percent. British analysts examining the impact on children note that the weakened family damages society as well, both in taxes and in other social costs, including crime: Armed robberies increased by a factor of eleven in England and Wales between 1970 and 1991.[11]

The United States is heading in the same direction. Census Bureau figures released in August 1994 show that 19 percent of white children live in single-parent families. Among Hispanics and blacks, the proportions of children living in single-parent families are 31 percent and 49 percent, respectively. The deleterious influence of single-parent households on welfare costs is apparent to most observers, regardless of political persuasion. Solid welfare reform depends on reducing the proportion of children living in single-parent families. This obviously entails a drastic slowing of illegitimate births, especially illegitimate births to teens. The consensus about illegitimacy and welfare reform breaks down, however, when it comes to how births to unmarried teens are to be reduced. Liberals often recommend increased contraceptive education for teenagers and resort to abortion when contraception fails. Conservatives generally favor a new emphasis on responsibility, virtue, and sexual abstinence in a broad cultural setting.

THE CLINTON ADMINISTRATION AND WELFARE REFORM: A CASE STUDY

In the 103rd Congress, the Clinton Administration's welfare reform bill (S. 2224) sat sidetracked as intense attention was given health care reform. The bill proposed "to redesign the program of aid to dependent children...[and among other things] prevents dependency...." Detailed summaries of the bill and Sections 505 and 506 also described the "Teen Pregnancy Prevention Grant Program" by which 1,000 schools and community-based groups would receive grants for "teen pregnancy prevention strategies." Although the bill itself never mentioned the abstinence strategy, this six-page narrative summary includes three surprising references: to "the delay of sexual activity" (twice) and to "premature sexual behavior" (once). Given the growing cultural awareness of the inherent soundness of a prevention strategy based on sexual abstinence, this language seemed to promise dramatic change—but not for long. These references, when translated into the bureaucratic language of Clinton Administration planners and policies, were contradicted and emptied of meaning.[12]

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10 Foreword by Daniel Patrick Moynihan in James C. Vadakin, *Children, Poverty and Family Allowances* (New York: Basic Books, 1968).

11 Tom G. Palmer, "English Lessons: Britain Rethinks the Welfare State," *The Wall Street Journal*, November 2, 1994.

12 For a discussion of the Clinton welfare reform proposal, see Robert Rector, "How Clinton's Bill Extends Welfare As We Know It," Heritage Foundation *Issue Bulletin* No. 200, August 1, 1994.

Reading the Fine Print. Consider what the Administration meant by "delay of sexual activity" or "premature sexual activity." In the first place, neither "abstinence" nor any related term was to be found in the Administration document. There was no statement that sexual activity is inappropriate for teens or best expressed within marriage. Instead of clearly stating its intentions, the Administration discussed teenage sexual activity with such vague words as "delay" or "premature." Clinton's policy team at the Department of Health and Human Services has a long track record of using ordinary language in misleading ways. For instance, sexual intercourse is "premature" for pre-teens or early teens (11 or 13-year-olds) and should be "delayed" until the age of 16 or 17 years, at which point programs that teach sexual "delay" can shift to contraceptive education. The basis for this educational shift was apparent in the language of the bill summary:

> Particular emphasis must be paid to the delay of sexual activity and prevention of pregnancy before marriage. Programs that combine these elements have shown the most promise, especially for adolescents who are motivated to avoid pregnancy until they are married.

It becomes apparent that "delay of sexual activity" and "prevention of pregnancy" are two very different and contradictory directions.

The Clinton document is further decoded by examining the next sentence: "Programs that combine these elements have shown the most promise." The word "combine" refers to the current vogue in sex education of giving the "delay/abstinence" message to young children and then "combining" it with the contraceptive strategy for middle and older teens. Although touted as having "the most promise," this approach has not been effective; only the abstinence component has shown any positive effect.[13]

These combination programs are called "abstinence plus" by their supporters, largely because they find a way to include the government contraceptive promotion programs that planners favor. The notion that adolescent sexual activity can be divided into two categories—premature and mature—did not originate with the policymakers of the Clinton Administration.[14] Yet only in a time of policy confusion could such a notion gain a foothold in government programs. Like "safe drug use," "mature adolescent sexual activity" is a contradiction in terms.

EVOLUTION OF SOCIAL RESPONSE TO UNWED PREGNANCY

Expert opinion about teenage pregnancy has undergone continuous change through the last three decades. The grave consequences of high rates of illegitimate births among blacks were first brought to the public's attention by Senator Moynihan in the early 1960s when he was a policy advisor in the administration of President Lyndon B. Johnson. At the time Moynihan issued his first earnest warnings, the proportion of ille-

13 Douglas Kirby, Richard P. Barth, Nancy Leland, and Joyce V. Fetro, "Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking," *Family Planning Perspectives*, November/December 1991, p. 262.

14 Sex Information and Education Council of the U.S., *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade*, October 16, 1991.

gitimate births among blacks was about 28 percent—slightly less than the proportion in society at large today.

In the late 1960s, rising levels of premarital sexual activity among many ethnic groups led to concern about the epidemic of births to teenagers. This notion of an epidemic of teen births flourished among policymakers and the public for two decades, despite the fact that demographers such as Maris Vinovskis have shown that the teenage birth rate *fell* steadily through the 1960s and 1970s. Even a pause in this decline in the late 1980s did not erase the fact that the birth rate to teenage mothers is significantly less now than forty years ago. The number of births to unmarried teens, however, has risen dramatically. The understanding that the epidemic of births to teen mothers is really an epidemic of illegitimacy did not gain currency among policymakers until the 1990s.

The success of programs designed to resolve social problems such as teen illegitimacy depends on how those problems are defined. To talk of an "epidemic of births" among teens suggests that teen pregnancy is a medical problem, which in turn suggests that medical science can produce a remedy. In the minds of many social scientists and government policymakers, the obvious answer to this supposed medical problem was to provide teens with birth control drugs and devices. Thus, the federal government's formal family planning program, Title X, passed in 1970 with the general understanding that it would continue to follow the practice of previous efforts by providing services only to married women, soon became strongly oriented to providing contraceptives to unmarried teens.[15]

Due to the huge growth in the number of abortions among adolescents during the middle and late 1970s, the number of births to teenage mothers declined while the number of teen pregnancies rose dramatically. By the mid-1980s, efforts to reduce teenage pregnancy through sex education and contraception were having no beneficial effect—perhaps even a deleterious effect.[16] About this time, however, it was becoming clear that AIDS also could be a disease of heterosexuals. Very quickly, the problem of teenage sexuality was redefined: The major threat now was sexually transmitted disease.

Until a few years ago, the prevailing view among health educators such as Debra Haffner[17] was that it was useless to try to frighten teenagers with the consequences of sexual activity. Increasing fear about AIDS, for instance, would render teens unable to take positive action, such as condom use, which could reduce the risk of AIDS transmission. Of course, in this view, the possibility of paralyzing teenagers with fear went only so far; they did not believe, for instance, that fear-induced paralysis would render teenagers reluctant or unable to engage in sexual activity.

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15 In the quarter century since passage of Title X, about $3 billion has been appropriated for this program. About a third of this amount has gone to support services for teenagers.

16 See William Marsiglio and Frank Mott, "The Impact of Sex Education on Sexual Activity and Contraceptive Use and Premarital Pregnancy Among American Teenagers," *Family Planning Perspectives*, Vol. 18 (1986), pp. 151-162, and Melvin Zelnik and Young J. Kim, "Sex Education and Its Association With Teenage Sexual Activity, Pregnancy and Contraceptive Use," *Family Planning Perspectives*, Vol. 14 (1982), pp. 117-126.

17 Debra Haffner, "It's Wrong to Teach Fear of Sex," *The Wall Street Journal*, March 20, 1992.

The evolution of sex education programs has been described at length by Douglas Kirby, Ph.D., of ETR Associates in Scotts Valley, California. Kirby has categorized sex education curricula into four generations. The first generation "focused primarily on increasing students' knowledge about sexuality and on emphasizing the risks and consequences of pregnancy."[18] The second placed more emphasis on values clarification and decision-making skills. The third developed "in reaction or opposition to" the first two. Kirby describes the third generation in the following terms:

> Concerned that the first two generations of programs were "value free," and supported by a moralistic and ideological fervor, a different group of people developed programs consistently emphasizing the message that young people should not engage in intercourse until marriage. To avoid any possibility of a double message, these programs commonly did not discuss contraception.[19]

The fourth generation of programs, including one of Kirby's, "represents a synthesis of the first three." These programs "are neither value-free nor moralistic....Instead, they emphasize that it is a good idea for young teenagers to delay sex and that it is important for all young people to practice effective contraception if they are going to have sex."[20]

Kirby notes that the first generation of programs imparted knowledge about sex but failed to achieve the desired results: "It has subsequently become more widely recognized ...that knowledge about issues such as contraception is only weakly related to behavior, and that increased knowledge may not produce much of a reduction in risk-taking behavior."[21] As for the second generation, which stressed values clarification, "when specific values were not given prominent emphasis in the course, there was little evidence of impact."[22] Kirby concedes that the third generation (based on abstinence) managed in the short run to change attitudes about premarital intercourse. With regard to changing behavior through abstinence, Kirby remarks that few published studies have examined this topic and notes that "the methods used in those studies have been somewhat limited, but thus far those evaluations indicate that the programs did not delay intercourse or reduce frequency of intercourse."[23]

Kirby reserves his praise for fourth-generation programs, which he says have shown an ability to delay the initiation of intercourse. He arrives at this result by assigning a program, Postponing Sexual Involvement, to the fourth generation despite the fact that it was funded by the federal government as an abstinence-only program. To justify his categorization, Kirby argues that "Although the program focused on delaying sexual intercourse, Postponing Sexual Involvement was not moralistic, and it differed in other important ways from the third generation of programs."[24] The nature of these important differences is never explained.

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18 Douglas Kirby, Richard Barth, Nancy Leland, and Joyce Fetro, "Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking," *Family Planning Perspectives*, November/December 1991.

19 *Ibid.*, p. 254.

20 *Ibid.*

21 *Ibid.*

22 *Ibid.*

23 *Ibid.*

This account of the evolution of teen pregnancy prevention programs is artificial and does not comport fully with the classifications of funding agencies. Moreover, Kirby's classifications dilute the effect of abstinence-only programs. Programs that are similar in content and approach are segregated according to whether they are considered moralistic. This points out a central feature of the academic discussion of adolescent sex: Academics and policymakers generally focus only on the physical consequences of sexual activity, such as pregnancy and sexually transmitted disease. Psychological and spiritual consequences of early sexual involvement rarely receive consideration. Even topics like the coercion of teenage girls by older males, which would seem certain to elicit strong reactions, until very recently have not garnered much attention from academics and policymakers.

Though Kirby's analysis fails to give abstinence programs the credit they deserve, it does contain some interesting news: Abstinence programs can be successful without an overt appeal to traditional morality. There appears to be enough evidence about the health and career advantages of abstinence to persuade most young adolescents that it is the best course to follow. Indeed, overt appeals to morality actually may work against the success of an abstinence program for certain teenage audiences. For those adolescents who regard themselves more as consumers in a marketplace of ideas than as heirs to the intellectual heritage of their parents, traditional values and good ideas must be marketed creatively.

Fourth-generation, or "abstinence plus," sex education programs are sophisticated and well-presented but have not demonstrated success in delaying the initiation of sexual activity. They can claim success only by defining it in very broad terms. They claim success when sexual initiation is delayed, when frequency of sexual activity is decreased, or when contraceptive use is increased. Promoters of "abstinence-only" programs in general do not even bother to measure frequency of sexual activity or use of contraceptives, for they realize that social and psychological damage results from the premature initiation of sexual activity. Using contraceptives merely avoids part of the adverse consequences of sex for a teen.

Ignoring the psychological realities of teenage sex also helps demonstrate why "abstinence plus" programs are not likely to be successful. Teenagers in these programs understand that they are being offered two mutually exclusive lines of behavior by adults associated with trusted institutions. If these options are presented as equally good, teens naturally will pick the one that costs them less—or, put another way, that forces them to relinquish less. It is no surprise that even highly touted "abstinence plus" programs such as Reducing the Risk have not managed to increase abstinence.

ADOLESCENTS AND THE RISKS THEY FACE

Many adolescents face multiple risks in the transition to adulthood: lack of future orientation and discipline, poverty, dropping out of school, family instability, pressures for sexual activity, alcohol and drug abuse. Although adolescents, because of their develop-

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24 *Ibid.*

mental status, tend to misunderstand and minimize the seriousness of these risks, the phenomenon is more pronounced in youths who lack real direction in their lives.[25]

Teenagers generally have other developmental limitations as well. According to developmental psychologist Erik Erikson, adolescents are incapable of the intimacy that comes with committed love. Also, on the practical side, adolescents are poor and inconsistent contraceptors even though current oral contraceptives are low-dose formulations that should be taken every day at the same time.

In dealing with children with multiple risks, the Clinton Administration argues that "for those populations where adolescent pregnancy is a symptom of deeper problems, education and contraceptive services alone will be inadequate; they must be part of a much wider spectrum of services." This correctly identifies the need for intensive services for adolescents who believe, because of cultural or peer pressure, that having children out of wedlock is a desirable goal. One defect of this strategy, however, is the inclusion of the contraceptive element; adolescents would be left to the same risks and cultural pressures, only with suggestions to go about them more carefully. This guarantees that the "new" approach would collapse upon itself.

Personal Responsibility. A safe transition to adulthood requires the development of self-respect, self-restraint, and orientation to achievable life goals, summed up in the traditional recognition that the successful and good life requires the cultivation of virtue. Adult direction, good counsel along the way, and growth in virtue are all essential to youth. Yet adolescents with multiple risks (such as unformed families, low levels of education, or low socioeconomic status) are excluded all but systematically from this vision of life; it is assumed to be impossible for them. At the same time, they are exposed constantly to the most self-destructive behaviors, including illegal drug and alcohol use. Adolescents at high risk for self-destructive behavior also have the greatest need for life orientation, hope, and virtue.

If personal virtue is the key to responsible adulthood, programs that claim to prevent dependency must address the real needs of adolescents by focusing on these elements and equipping young people for adult responsibilities. Any other program modifications will not be worth the effort.

TEENS, CONTRACEPTION, AND BIRTH

Casual observers often attribute the rise in single-parent households to a putative rise in the teen birth rate. This is not entirely accurate. As noted above, historically speaking, the teen birth rate is at a low level. The National Center for Health Statistics makes this point precisely: In 1970 the birth rate for 15-19 year olds was 68.3 for every thousand

25 D. Boyer and D. Fine, "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Mistreatment," *Family Planning Perspectives*, Vol. 24, No. 1 (1992), pp. 4-19. Note particularly page 11, where the authors state that prolonged victimization of a population of adolescent girls "may have disrupted their developmental processes and undermined their basic competence." This explains why "Rational, skills-oriented approaches used in teaching sexual decision-making and contraceptive use...have met with limited success for a large number of adolescents who continue to become pregnant and are at high risk of sexually transmitted disease."

girls of that age; in 1992, it was 60.7. During the same period, the rate of births to unmarried teens almost doubled, rising from 22.4 per thousand to 44.6 per thousand.[26] Nevertheless, the birthrate for unmarried teens is still less than the birthrate for unmarried women in their twenties. It is these illegitimate births among adolescents and young adults which have particular relevance to welfare programs and policies. The epidemic of illegitimacy among all age groups is a cultural rather than a biological or technical problem. The remedy must be cultural as well.

President Clinton's Work and Responsibility Act of 1994 is probably a good indication of future liberal policy proposals. It acknowledged that the increase in illegitimate births to adolescent mothers has a serious impact on the nation's social welfare system, and Sections 505 and 506 ostensibly answered the problem of births to unwed teenage mothers. Unfortunately, it seems the Clinton plan tried to rectify the problem of early unwed motherhood through sex education and school-based clinics featuring contraception. The Work and Responsibility Act presupposed these techniques would cause teens to have intercourse in ways that reduce the likelihood of pregnancy and sexually transmitted disease. The Act identified this as "sexual responsibility."

This attempt to make sexual activity safe for teens is not novel; its failures are visible everywhere. Except for a pause in the early 1980s, pregnancy rates for 15-19 year olds have risen over the last 25 years to the present high of 111 pregnancies for every thousand girls.[27]

Another unfortunate physical consequence of the attempt to render sex safe for teens is an epidemic of sexually transmitted disease. The U.S. Public Health Service estimated in 1989 that one in four sexually active teens will be infected eventually with a sexually transmitted disease. The federal Centers for Disease Control estimate that there are at least 12 million new cases of such disease every year. Since many sexually transmitted diseases such as AIDS, herpes, genital warts, and hepatitis B have a viral etiology, they are incurable. Because viral STDs are lifelong, some estimates suggest that one in five Americans eventually will contract a viral STD.[28] Obviously, not all of these people are adolescents, but in an era of multiple sexual partners, everyone in the pool of sexually active people is at risk.

In addition, certain nonphysical dangers of early sexuality often are ignored, either because they are not visible or because they are not easily quantifiable. Poor academic grades and a decrease in orientation toward the future have been documented among adolescents who initiated sexual intercourse prior to marriage.[29] Unfortunately, disillusionment with life (sometimes called a broken spirit) is a consequence that is not susceptible to public health analysis.

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26 *Monthly Vital Statistics Report*, National Center for Health Statistics, Vol. 43 (October 25, 1994).

27 S. Henshaw, "Teenage Abortion, Birth and Pregnancy Statistics by State, 1988," *Family Planning Perspectives*, June/July 1993, pp. 122-126.

28 Thomas E. Smith, Executive Director, Medical Institute for Sexual Health, Austin, Texas, personal communication, August 10, 1995.

29 Billy, Landale, Grady, and Zimmerlee, "Effects of Sexual Activity on Adolescent Social and Psychological Development," Report to the Office of Population Affairs, Department of Health and Human Services, June 1986.

Family disruption and a tendency to engage in other risky behaviors such as drinking also are associated with early sexual activity. Recent studies performed for the state of Illinois by John Vessey, Ph.D., of Northwestern University quantify several risk factors for premarital sexual activity. Not having two parents in the home and believing that parents accept adolescent sexual activity are associated with a doubling of the chances that a teen will have premarital sex. Smoking and frequent drinking are associated, respectively, with fourfold and sixfold increases in the likelihood of premarital sex. Believing that condoms are safe is associated with a fivefold increase.[30]

REASONS FOR FAILURE OF "RESPONSIBLE TEEN SEX"[31]

The inability of adolescents to shield themselves from the adverse consequences of early sexual activity is not due to poor technology. Theoretically, there is not much room for improvement in the effectiveness of hormonal contraceptives (oral pills or implanted capsules). There may be some room to reduce their unhealthful or unpleasant side effects, but the natural tendency of scientific research is to concentrate on the more important risks, such as breast cancer, heart attack, or stroke, rather than on minor side effects like acne, weight gain, or hair loss that are important to image-conscious teenagers. Considering the purpose of hormonal contraception—to alter the natural process of ovulation—some side effects are unavoidable.

By far the greatest impediments to efficient pregnancy prevention through contraceptives are human error and failure to use these devices. According to one large, well-controlled study, 58 percent of women forgot to take their oral contraceptive pills every day, and 80 percent failed to take them at the same time every day as prescribed.[32] This study included women of all ages, with the mean age over 20; it is recognized generally that the level of compliance with contraception protocols among teenagers is much worse than for the population of women as a whole. This helps explain why there are millions of unplanned pregnancies even though 90.1 percent of sexually active American women use some type of contraception.[33] Failure to comply with professionals' prescriptions must be regarded as one of the immutable facts of contraceptive life.

It may be argued that failure to follow medical recommendations does not affect so-called passive methods of contraception, such as Norplant. Hence, when Norplant was approved for the market in 1991, many family planning advocates hailed it as the "magic bullet" that would end unintended pregnancy among teenagers and others likely to forget their pills. Within months, all state Medicaid programs were paying for Norplant.

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30 Dr. John Vessey, personal communication, May 6, 1995.

31 The "responsible sex" notion does not work for teen adolescents. There are many adolescents who, for complex cultural reasons, do not even accept the goals of "responsible sex," as journalist Leon Dash demonstrated forcefully in his book about child-bearing adolescents in Washington, D.C., *When Children Want Children* (New York: William Morrow Co., 1989). Several social scientists, such as Arlene Geronimus, have shown why an impoverished teenage girl might reasonably decide, in view of her social and economic prospects, to bear her children early and out of wedlock.

32 Deborah Oakly, Susan Sereika, and Erna-Lynn Bogue, "Oral Contraceptive Pill Use After an Initial Visit to a Family Planning Clinic," *Family Planning Perspectives*, July/August 1991, pp. 150-154.

33 M. S. Burnhill, "Adolescent Pregnancy Rates in the U.S.," *Contemporary Ob/Gyn*, February 1994, p. 27.

Researchers became concerned that the euphoria surrounding the arrival of a low-effort, long-term contraceptive might cause users to become careless about their reproductive health practices. With funds from the U.S. Public Health Service, a large study was initiated on a population of Medicaid women in Arkansas, one of the leading states in Norplant use. The study confirms some of the fears of reproductive health professionals: Medicaid women with Norplant are more likely to miss regularly scheduled gynecological screenings, more likely to contract sexually transmitted diseases, and less likely to get needed services. This study contains no information on whether individuals with Norplant have more sexual partners, though such data certainly would be relevant to the spread of sexually transmitted disease.[34] Another large study, conducted in Baltimore to compare adolescent and adult Norplant users, revealed that only 13-18 percent of users returned for their routine follow-up examinations.[35]

When confronted with the failure of prescription contraceptives to protect against sexually transmitted disease, proponents of birth control for adolescents respond with condoms. But family planning professionals historically have been reluctant to recommend condoms for pregnancy prevention because of their high failure rate. The contraceptive failure rate among young, low-income women who use condoms, oral contraceptives, or diaphragms is shown below.

PERCENTAGES OF NEVER-MARRIED WOMEN EXPERIENCING CONTRACEPTIVE FAILURE DURING FIRST 12 MONTHS OF USE, BY AGE AND METHOD

Age of user	Pill	Condom	Diaphragm
Less than 20 years	12.9%	27.3%	37.3%
20-24 years	15.0%	31.1%	42.1%

Source: E.F. Jones and J.D. Forrest, "Contraceptive Failure Rates Based on the 1988 National Survey of Family Growth," Family Planning Perspectives, January/February 1992, pp. 12-19.

These rates reflect failure to prevent pregnancy. There are no specific data about the failure rate of barrier contraceptive methods in preventing sexually transmitted diseases. Some published studies indicate slippage and breakage rates exceeding 14 percent, even among experienced condom users.[36] It would be a mistake, however, to equate every instance of slippage and breakage with an accidental pregnancy or the transmission of a disease. Condoms often slip or break without resulting in an STD or a pregnancy; conversely, an STD or a pregnancy can occur in spite of an intact condom. Even an intact

34 T. Freni, M.D., Arkansas Health Department, personal communication, November 3, 1994. Polaneczky *et al.* recently published an article in *The New England Journal of Medicine* (Vol. 331, No. 18) containing findings from a study comparing post-partum teenaged Norplant users to oral contraceptive users. Forty-two percent of the Norplant users and 36 percent of the pill users contracted a sexually transmitted disease in the follow-up period. This difference was not statistically significant. There was no difference in clinic visits. However, in view of the small size of the study group—48 people received Norplant—it should not be given as much weight as the Arkansas study, which was over ten times as large. The Arkansas study has yet to be published, though a report has been sent to the U.S. Public Health Service.

35 V. E. Cullins *et al.*, "Comparison of Adolescent and Adult Norplant Levonorgestrel Contraceptive Implants," *Obstetrics and Gynecology*, Vol. 83 (1994), pp. 1026-1032.

36 Trussel, Warner, and Hatcher, "Condom Slippage and Breakage Rates," *Family Planning Perspectives*, January/February 1992, pp. 20-23.

condom cannot necessarily prevent the spread of serious sexually transmitted diseases. Human papillomavirus (HPV), the agent which causes genital warts and the root cause of most of the nation's 6,000 cervical cancer deaths per year, can exist in parts of the genital region not covered by condoms.[37]

Teens and Condoms. In view of high contraceptive failure rates, responsible reproductive health professionals have concluded that the minimum standard for reducing the chances of pregnancy or sexually transmitted disease is to use a hormonal method and a barrier method simultaneously. This "dual use" is what the Public Health Service recommended in 1990 as a fallback position for adolescents who do not remain abstinent.[38] More recently, Dr. David Kessler, head of the Food and Drug Administration, correctly decried the tendency of health professionals to give dangerously insufficient advice regarding contraception: "you don't hear people saying use Norplant plus a condom...or oral contraceptives plus a condom. That's not being said and it needs to be said."[39]

Unfortunately, family planning professionals have neglected this message. Perhaps they are reluctant to spread the message of dual use because they recognize that it complicates sexual activity and, thus, that many sexually active people will be loath to heed it. Acceptance of dual contraceptive methods is very low; the Public Health Service estimates that only 2 percent of sexually active teens attain even this insufficient standard of risk reduction.[40]

What dooms dual use as a means of risk reduction for teens is what has always plagued barrier methods and hormonal contraceptives separately: Many adolescents simply do not want to use them. This indifference to contraception points to a central fact of developmental psychology: that teenagers and adults evaluate risks differently. The cognitive pattern that characterizes most people in early and middle adolescence (sometimes called concrete operational thought) is characterized by haphazard processing of information and failure to anticipate future outcomes of actions.[41] This predisposition makes it difficult for teens to use contraception effectively and consistently. In many cases, their low ability to take positive action to reduce the risks associated with sex is impaired further by drugs or alcohol. The failure to take these facts into account has undermined many pregnancy prevention programs, especially those based on contraception.

The contraceptive approach to adolescent pregnancy prevention faces also more formidable obstacles than teenagers' psychological disinclination to use inconvenient contraceptive methods. In some areas, statistics show that 70-90 percent of the children of teenage mothers were fathered by men in their twenties.[42] Thus, what is commonly described as the teen pregnancy problem actually involves more than teenagers.

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37 Darron R. Brown and Kenneth H. Fife, "Human Papillomavirus Infections of the Genital Tract," in *Medical Clinics of North America*, ed. David H. Martin (Philadelphia: W. B. Saunders Company, November 1990), pp. 1455-1462, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, U.S. Public Health Service, 1990, p. 421.

38 *Healthy People 2000*, p. 196.

39 Quoted in Sandy Rovner, "Contraceptable Labels to Reflect Protection," *The Washington Post*, April 13, 1993.

40 *Healthy People 2000*, pp. 196-197.

41 A brief but informative summary of adolescent developmental psychology as it relates to teen pregnancy has been written by Mary Beth Seader Style, M.S.W., Vice President for Policy and Practice at the National Committee for Adoption in Washington, D.C. This article, "The Developmental Stage of Adolescence," is available from the author upon request.

Men in their twenties enjoy a certain status with teenage girls simply because of their age. In the current social climate, there is little disadvantage to a young adult male in fathering a child out of wedlock. Perversely, he incurs financial responsibilities only if he admits paternity. In many states, a declaration of paternity made in the hospital when his child is born has no legal effect; he must repeat the statement in court. These slightly older men are not above using force or coercion to make sexual conquests. Social science research only recently has begun to plumb the depths of coercive sex suffered by teenagers.[43] It is no wonder that in a national survey, a plurality of teens regarded pressure to have sex as the greatest threat to their well-being.[44]

The fact that men who impregnate teenage girls are often in their twenties points to a serious problem in current adolescent pregnancy-prevention programs: We cannot reach these young adults with school-based campaigns. These young men are not impressed with any contraceptive method because fathering a child out of wedlock brings them only advantages (unless they marry). Previous cultural and legal prohibitions about older males' being involved sexually with teens have loosened. As damaging as this is in itself, it leads to another problem: Teenage males, who tend to model their actions on the behavior of their slightly older counterparts, try to act out their own version of this life. Thus, a vicious cycle is born. In terms of sexually transmitted disease, substance abuse, and nonmarital sexual activity, the early twenties are an even more troubled age than the teen years.

FALSE DIAGNOSES

Adolescents do not lack information about sex. Aside from the continual media onslaught, there are numerous sources of formal education about sexuality, contraception, and sexually transmitted disease. A recent survey shows that 93 percent of U.S. high schools offer classes on sexuality and AIDS.[45] According to a national study of 15-19 year old males, a large majority (79 percent) had received formal instruction about birth control. Unfortunately, only 58 percent had received formal instruction about resisting pressure to engage in sexual activity.[46]

It is also clear that the high rate of repeat pregnancy among teens cannot be attributed to ignorance about sexual matters. A study of contraceptive use and repeat pregnancy among welfare-dependent teenage mothers found that half had become pregnant again within two years even though the majority were using some method of contraception.[47]

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42 Michael Males, "School Age Pregnancy: Why Hasn't Prevention Worked?" *Journal of School Health*, Vol. 63, No. 10 (December 1993), pp. 429-432.

43 P. I. Erickson and A. J. Rapkin, "Unwanted Sexual Experiences Among Middle and High School Youth," *Journal of Adolescent Health*, Vol. 12 (1991), p. 319. See also Boyer and Fine, "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Mistreatment," *op. cit.*

44 Poll by Roper Starch Worldwide, New York, January 25-February 8, 1994.

45 S. Rodine, *Spotlight on Washington, D.C.*, Spring 1994, p. 3.

46 Ku, Sonenstein, and Pleck, "The Association of AIDS Education and Sex Education with Sexual Behavior and Condom Use Among Teenage Men," *Family Planning Perspectives*, June 1992.

47 Maynard and Rangarajan, "Contraceptive Use and Repeat Pregnancies Among Welfare-Dependent Teenage Mothers," *Family Planning Perspectives*, September/October 1994.

Funding for Pregnancy Prevention. Despite its frequent portrayal as a national problem, federal funding for adolescent contraception is ample. Overall, the federal government spends about $1 billion per year on family planning. These expenditures include Title X of the Public Health Service Act (family planning for low-income persons) and Title XIX of the Social Security Act (Medicaid, which pays for more contraceptive services than any other program), but not matching funds from the states or other institutions. Judging from the age distribution of Title X clients, about $300 million of this money is devoted to adolescents each year. On the other hand, the Office of Adolescent Pregnancy Programs, which runs the only federal program dedicated to promoting sexual abstinence (Title XX of the Public Health Service Act), spends about $1.9 million for that purpose annually. If there is a funding problem for adolescent sexuality programs, it is only that current funding is misdirected.[48]

Asked to explain the absence of evidence that their programs work, proponents of contraceptive education fall back on arguments of "face validity." All this means is that, on its face, a program seems as if it ought to work. When "experts" state that contraceptive education programs have "face validity," they are saying that they believe imparting information, regardless of its quality or evidence of any effect, is good. Yet proponents of abstinence in Congress and elsewhere have not been able to invoke face validity to support their programs. In the hands of abstinence proponents, face validity is considered offensively moralistic. Thus, in a field with a perennial scarcity of solid data, policy arguments all favor the contraceptive side.

Without any persuasive evidence that it benefits adolescent development, or that it is effective when used, the contraceptive approach is regarded most appropriately not as a pragmatic policy choice, but as an ideology, though admittedly one that remains widely respected.[49]

WHAT WORKS TO REDUCE ADOLESCENT PREGNANCY

When seeking what works to reduce teenage pregnancy, federal and state policymakers should not search primarily among federal government programs. Some successes have been achieved in the Title XX Adolescent Family Life program, but its tiny size and the bureaucratic and legislative constraints under which it labors have prevented it from having a substantial impact.[50]

The Title XX program does serve, however, as a useful point of departure in exploring successful abstinence programs. The program funded ground-breaking research on the precursors and consequences of sexual activity among unmarried adolescents. Among its

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48 Figures for expenditures on family planning from *Report to Congress on Federal Government Expenditures* (Moyer Report), June 1993, and U.S. Public Health Service reports on clinic services.

49 For an excellent analysis of this ideology, its shrewd political rhetoric, and its negative effects on children, see Barbara Dafoe Whitehead, "The Failure of Sex Education," *The Atlantic Monthly*, October 1994, pp. 55-80.

50 Clinton Administration officials, including former Surgeon General Joycelyn Elders, did not agree with the abstinence thrust of Title XX and proposed to eliminate its funding entirely. The Administration's attempt to dismantle the Adolescent Family Life Act was opposed successfully by several members of the Senate and House who insisted that there must be at least one federal program dedicated to promoting adolescent abstinence.

findings were that a family's pattern of communication affected the abstinence behavior of adolescents. In particular, good communication between adolescents and their mothers tended to promote abstinent behavior. Title XX-funded research also documented that adolescent initiation of sexual intercourse had a negative effect on the reported academic grades of white males, as well as on the college aspirations of white females.[51]

Influenced perhaps by polls which found that 65 percent of teenagers thought the most effective way to convince their peers to postpone sex would be to describe the dangers of diseases like herpes and AIDS,[52] many early Title XX programs emphasized the adverse consequences of early sexuality. This approach failed for two major reasons. First, these programs tried to focus teens' attention on the grim facts of AIDS and sexually transmitted disease while AIDS advocates and most of the public health establishment were asserting that grim outcomes generally could be avoided with condoms. Second, the adverse consequences approach did not give sufficient weight to the statements of adolescents who actually had abstained. According to a poll of adolescents who abstained (the Gallup Study of American Youth, 1977-1988), 55 percent were concerned about pregnancy, but 75 percent wanted to save sex until marriage.

Nabers Cabaniss Johnson, Deputy Assistant Secretary for Population Affairs at the U.S. Department of Health and Human Services from 1987-1990 and director of the Title XX program, credited a project conducted by the Search Institute of Minnesota with finding that "knowledge alone has little effect on sexual decision-making and that teens' own values and strength of conviction about what is right far outweigh peer pressure or fear of consequences."[53]

Willingness to abstain, then, is the heart of the matter. It is unlikely that the desire to wait can be taught in the didactic sense. But if the culture at large, the neighborhood culture, or even the subculture at school supports the virtue of abstinence, well-designed programs can help a teen to practice it. Abstinence programs over the years have developed effective methods, such as resistance skills, which teens can use to implement their convictions. American culture must provide the concepts of virtue toward which adolescents can strive.

The Title XX program has funded about 75 abstinence projects across the country since 1981. Remarkably, by law, this portion of Title XX could be no more than half as big as the portion devoted to caring for teens already pregnant or rearing young children. The abstinence projects were located in urban, suburban, and rural areas. Because Title XX was a demonstration program, the projects it funded generally were quite small.

DEMONSTRATED EFFECTS OF ABSTINENCE PROGRAMS

Ideological opponents of the abstinence approach, such as former Surgeon General Joycelyn Elders, suggest that abstinence cannot be promoted successfully among teens. Yet even those who oppose abstinence programs recognize that the small projects funded

51 Billy, Landale, Grady, Zimmerlee, "Effects of Sexual Activity on Adolescent Social and Psychological Development," *op. cit.*

52 Louis Harris and Associates, "American Teens Speak: Sex, Myth, T.V. and Birth Control," New York, 1986.

53 Nabers Cabaniss, "A Look at the Adolescent Family Life Act," *The World and I*, September 1989.

by Title XX generally have produced favorable cognitive and attitudinal results. These programs meet the standard stated by the summary of Sections 505 and 506 in the Clinton plan, and yet they have no real chance of approval as part of the Clinton Administration's program.

The "gold standard" among sex education or abstinence programs is not whether they increase knowledge, or even whether they change attitudes. The important achievement is to affect behavior. In this regard, the Title XX program has enjoyed notable success.[54]

A program called Preventing Sexual Involvement (PSI) was conducted by Emory University faculty members at Grady Memorial Hospital in Atlanta, Georgia, in 1983. Since it received funding under Title XX, it was by definition an abstinence-only program. The study population was entirely urban, poor, and African-American. A scientific evaluation of PSI showed that adolescents who went through the program were significantly less likely to initiate sexual activity than similar adolescents in a control group. The beneficial results were recorded in a Public Health Service document entitled "Adolescent Family Life Program; Highlights from Prevention Projects":

> During the year that the students participated (eighth grade), nonprogram students were five times more likely to begin sexual activity during the school year than were program students (20 percent vs. 4 percent). The differences were greater for girls (15 percent vs. 1 percent) than they were for boys (29 percent vs. 8 percent). At the end of the ninth grade, the differences between non-program and program students continued (39 percent vs. 24 percent) even though no additional program involvement was provided.

Another program which apparently has reduced the level of sexual activity among adolescents is Reducing the Risk (RTR). Unlike PSI, RTR was not eligible for Title XX funding because it included a contraception message in addition to its abstinence message. The scientific evaluations of both programs specifically attribute resulting favorable changes in behavior to their abstinence components. As Kirby states in his evaluation of RTR, "In combination with the findings from the evaluation of PSI, this suggests that it may actually be easier to delay the onset of sexual activity than to increase contraceptive practice."[55]

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54 The measure of behavioral change usually is sexual activity, which is difficult to measure. At best, programs which have attempted to measure this variable have relied on the self-reporting of adolescents. Some analysts have suggested strongly that adolescents greatly exaggerate their sexual activity. Males, "School Age Pregnancy: Why Hasn't Prevention Worked?" Considering some of the extreme reports that have appeared recently in the social science literature—for example, that 13 percent of ten-year-old girls and 28 percent of ten-year-old boys in an urban population had initiated sexual intercourse—it seems likely that the self reports are exaggerated. D. Romer *et al.*, "Social Influences on the Sexual Behavior of Youth at Risk for HIV Exposure," *American Journal of Public Health*, Vol. 84, No. 6 (June 1994), pp. 977-985. This tendency to exaggerate coital activity is an important factor in teen sexuality because teens are highly influenced in their sexual behavior by what they think their peers are doing. This becomes a vicious cycle because teens consistently overestimate the sexual activity of their peers.

55 Kirby, Barth, Leland, and Fetro, "Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking," December 1991.

Another Title XX abstinence project was conducted by the American Home Economics Association. An independent analysis of data from Project Taking Charge, made by a federal evaluator, showed that this project also reduced the likelihood of premarital sexual activity among adolescents who participated in the program.[56]

Adolescent Acceptance of Abstinence. Other successful abstinence programs have been developed without funding from Title XX or any other government source. In the schools of Conway, Arkansas (population 38,000), a concerned parent named Thelma Moton and a group of volunteers have conducted the EXCEL program for three years. EXCEL accepts no government funds because of an abiding belief that promoting civic virtue is a community's own responsibility. With the expertise of volunteers from among medical professionals, educators, parents, and older students, EXCEL has provided semester-long programs for 1,300 junior high students each year. Though a scientific evaluation of the program has just been initiated, a preliminary survey showed that 27 percent of students in the program were sexually active as opposed to 31 percent of those who were not in the program.

The EXCEL program makes good use of the prestige of senior high school students willing to "admit" that they have not engaged in sex. Younger students report that they are relieved to hear these "admissions" because they remove the peer pressure to engage in risky activities. EXCEL uses the same method to reduce other risky behaviors such as drinking and drug use.

Like PSI and RTR, EXCEL teaches refusal skills, or methods by which students can resist pressure from peers to indulge in sex, drinking, or drugs without becoming a social outcast. Refusal skills are practiced through role-playing and are considered crucial by the EXCEL staff. According to Thelma Moton, "If you don't have refusal skills, you don't have a program."[57] Practicing refusal skills is common in successful risk-reduction programs. Clearly, today's adolescent culture filters out fewer expressions of deviancy. Though this creates a more tolerant society in a superficial sense, it also generates more overt pressure on teens to participate in activities they may consider frightening.

Contrary to the expectations of many adults, the majority of teens seem interested in what abstinence-based programs might have to offer. A survey of 1,000 girls conducted by Emory University found that of a dozen possible sex education topics, the most popular (chosen by 84 percent of the respondents) was more information on how to say "no" to a boyfriend's requests for sex without losing the boyfriend.[58] It is also evident from a February 1994 Roper Starch poll that 12-17 year olds regard the pressure to have sex as the prime threat to their well-being.[59] It seems obvious that adolescents have been calling on adults to protect them with reasonable behavioral limits. For many years, however, the vogue in child-rearing was to ignore such calls.

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56 Dr. John Vessey, personal communication, May 6, 1995.

57 Thelma Moton, personal communication, December 14, 1994.

58 Marion Howard and Judith B. McCabe, "Helping Teenagers Postpone Sexual Involvement," *Family Planning Perspectives*, January/February 1990, pp. 21-26.

59 "Teens Talk About Sex: Adolescent Sexuality in the 90's," Roper Starch Worldwide, April 1994.

Another common characteristic of successful programs is an approach that recognizes and responds to the needs of the individual.[60] For example, Washington, D.C.'s Best Friends program, directed by Elayne Bennett, works with girls who are at high risk for adolescent pregnancy. It asks them to remain abstinent through completion of high school. By pairing each girl in a mentoring relationship with a mature, stable woman, the program takes advantage of adolescents' tendency to model their behavior on the actions of slightly older people, thus starting what might be called a virtuous cycle. It also builds group identity and celebrates life events, such as completion of the school year and academic success. As of 1993, Best Friends had graduated over 500 young women without a single instance of pregnancy.

Further evidence that abstinence programs can have a positive effect on children with multiple risks is found in the Hoyleton project. Evaluators of this East St. Louis, Illinois, project funded by the Title XX abstinence program found that it combines classroom instruction with an after-school program to channel the energies and promote the further development of children enrolled in the classroom element. In addition, it involves parents as the primary sexuality educators of their children and provides academic tutoring, field trips, and games. This program attempts explicitly to change the cultural influences on children, thereby helping to give them a new vision of the possibilities beyond their present circumstances. This would be accomplished by helping teenagers avoid sexual activity, drug, and alcohol use, all of which are symptomatic of crisis in adolescents.

The programs that work are the ones that focus on adolescents as individuals during the transition to adulthood, a time fraught with risk, especially for those with weak or nonexistent parental assistance or other adult role models. These programs recognize, implicitly or explicitly, that the rise in adolescent pregnancy has significant psychological and cultural implications. Therefore, their approach is not merely to give large numbers of teens more information. Programs that have relied simply on dispensing information have not been successful in reducing teen pregnancies, whether the information was on abstinence or contraception.

WHAT POLICYMAKERS CAN DO

❶ Employ abstinence counseling.

Considering that about one young woman in five makes her first family planning visit before initiating sexual activity, there is a strong possibility that abstinence counseling could be effective.[61] Directive abstinence counseling has not been tried widely because it runs counter to the philosophical views of most family planning clinicians. But directive counseling is accepted and encouraged with respect to contraception. As we have seen, it is regarded by some experts as essential to gaining contraceptive compliance from teenagers.[62] If directive counseling can persuade teens to use cer-

60 *Prevention Report*, U.S. Public Health Service, March 1993, p. 11.

61 William D. Mosher and Marjorie Horn, "First Family Visits by Young Women," *Family Planning Perspectives*, Vol. 20, No. 1 (January 1988).

62 C. A. Nathanson and M. Becker, "The Influence of Client-Provider Relationship on Teenage Women's Subsequent Use of Contraception," *American Journal of Public Health*, Vol. 75 (1985), p. 33; see also interview with Michael Policar, medical

tain types of contraception, there should be no ethical objection to using it to promote abstinence.

If the teen already is sexually active, counseling could be geared toward what some teens describe as "secondary virginity." At least one survey has discovered that many teens who have had one occasion of sexual intercourse view it as an aberration they are unlikely to repeat.[63]

❷ Promote adoption counseling.

In cases where pregnancy already has occurred, adoption can break the cycle of welfare dependence. Despite its overwhelmingly positive outcome, however, only rarely is adoption described as an option by counselors who favor the contraceptive approach to reducing births among teens.[64]

❸ Establish parity for abstinence programs.

Congress is considering block grants as a major part of welfare reform. Abstinence programs can help stem the tide of early teen sexual involvement, but they must be accorded the same treatment that state and federally funded contraceptive programs now enjoy. Block grants should provide that opportunity. At the state level, officials can plant well-designed programs across communities so that they support each other and achieve a critical mass. The goal of government-supported abstinence campaigns is not necessarily to make it possible for every adolescent to be in a government-funded abstinence program. Rather, the idea is to make communities aware that government tangibly supports the idea of adolescent development rooted in abstinence, risk avoidance, and the attainment of positive life goals.

In an era when teens spend an average of 80 hours per week watching TV or listening to the radio,[65] it would be of inestimable value for state and local officials to provide grants to local private organizations for media campaigns to support the idea of abstinence—for example, to disabuse teens of the idea that they are the last virgins in their schools or neighborhoods.[66] Teens respond more to what they believe their peers are doing than to what their peers actually do. The success of local and nationwide abstinence promotion efforts like True Love Waits, which has been recognized even by national news magazines, demonstrates that teens will take up the abstinence message gladly if given a rallying point.

THE LONG-TERM SOLUTION: MASSIVE CULTURAL REALIGNMENT

"Abandoning the poor" is hardly a responsible position, yet AFDC, as we know it, itself abandons the poor. More taxpayers today are aware that AFDC recipients who enter the program as adolescent mothers will be the longest recipients, will remain mired in

director, Planned Parenthood Federation of America, in *Contemporary Ob/Gyn*, March 1994.

63 Dr. Terrence Olson, cited in *Healthy People 2000.*

64 Edmund V. Mech, "Orientation of Pregnancy Counselors Toward Adoption," cited in *ibid.*, p. 199.

65 Robert Wood Johnson Foundation, *Advances*, Fall 1993.

66 "Virgin Cool," *Newsweek*, October 17, 1994, p. 62.

poverty, and most likely will never marry or complete high school. At best, AFDC provides some income support for poor mothers and their children. At worst, it perpetuates cultural patterns that encourage illegitimacy, family non-formation, and difficulties for mothers and children steeped in the subculture of dependency.

The roots of today's dependency problem lie in a lack of hope for any achievable life goals and the collapse of cultural support for marriage and removal of any shame or stigma attached to illegitimacy. When this is recognized by those who make public policy, truly creative responses to the needs of these young women can be crafted. At the same time, promotion of abstinence, personal respect, and responsibility must be the "new" approach in any welfare reform proposals geared to preventing dependency. Abstinence programs must be part of a whole, unambiguous cultural message that promotes responsibility in all facets of life, including the sexual. Abstinence is the hallmark of responsibility. This message must be directed at both sexes and at all ages.

CONCLUSION

Well-designed abstinence programs can help teens as individuals, but the environment in which they live is also important.[67] Thus, it is necessary for state and local policymakers to support efforts, such as the Hoyleton project in East St. Louis and similar programs, which promote positive cultural influences in the lives of adolescents.

The Clinton Administration's claim that responsibility means using a contraceptive during non-marital sex turns the concept of responsibility on its head. The failed and feeble notion of sexual responsibility embodied in the Administration's Work and Responsibility Act would infect every program that accepts it. Participants would soon perceive that "responsibility" is a matter not of choices and behavior, but of acquiring new technology (or merely new terminology).

Policymakers instead should promote reforms that encourage personal responsibility. Only this can rescue another generation from dependency. Such a program would represent a true commitment to young people in their struggle to deal with difficult life issues. It would help them form and reach achievable goals, would give them hope, and would increase their chances of becoming responsible adults.

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67 K. L. Brewster, "Race Differences in Sexual Activity Among Adolescent Women: The Role of Neighborhood Characteristics," *American Sociological Review*, Vol. 59 (1994), pp. 408-424.