

Sexuality

INTRODUCTION

We live in an age in which we are overwhelmed by material and information of a sexual nature. The AIDS epidemic has raised the consciousness of many adults and adolescents about sexually transmitted diseases, and 'safe sex'. Sexually explicit material, not available a generation or two ago, is now freely obtainable. Glossy magazines depict idealised body shapes, fashions and trends. Understandably, some adolescents may feel pressurised to make themselves as sexually appealing as possible. In addition, societal norms about sexuality are rapidly changing with increasing numbers of teenagers becoming sexually active. The gap which has traditionally existed between boys and girls with respect to their sexual activity is also rapidly decreasing (Moore and Rosenthal, 1993).

The onset of sexual awareness coincides with puberty. Whereas boys begin to show an interest in girls in a *sexual* way, girls are more interested in boys in a *romantic* way (Harris and Liebert, 1987). It is during puberty that the body undergoes rapid change in terms of size, height, weight and distribution of body hair. The various hormones being released into the bloodstream at this time prepare the child physically for adult sexuality (Gallois and Callan, 1990). The first menstruation and first ejaculation are major psychological events that herald the end of childhood and signal to the young adolescent the imminence of adulthood. In this move towards adulthood, the adolescent is not only engaged in identity formation, but must also come to terms with his or her own sexuality. This needs to be meaningfully integrated into the self-identity with as little conflict and turmoil as possible (Conger and Petersen, 1984).

Puberty and its associated rapid changes also have implications for adolescents' self-perceptions of attractiveness and sexual desirability. Furnham and Stacey explain as follows (1991, 106):

the mass media constantly present fashionable types of beautiful people for adolescents (as well as adults) to compare themselves with. Adolescents often worry about their looks and physical attractiveness, and their capacity to appeal sexually. If there is a failure to meet current standards of acceptable looks, then this may well become an important personal problem.

Why is it that some adolescents engage in sexual intercourse at an earlier age than others? Are there specific identifiable causes of such behaviour? Are such teenagers more affected than others by hormonal, family or other social influences? Or is it simply a matter of chance as to who is likely to engage in sexual intercourse? These and other issues will be discussed in this chapter.

ATTITUDES TO SEX

Adolescents have quite clearly formed beliefs about sex-related matters. This has been demonstrated in a number of surveys. In a large-scale study of over 2000 British adolescents aged 10 to over 17 years, respondents were asked about the desirability of a range of sexual matters such as premarital sex and heterosexual relationships. Almost half of all respondents felt that society should tolerate all types of sexual relationships, not just heterosexual ones. Almost three-quarters approved of premarital sex. Just over 20 per cent of adolescents agreed that the main reason for having sexual relations should be to have children (Furnham and Gunter, 1989). The large-scale British study by Johnson and colleagues (Johnson et al., 1994) found that about 80 per cent of 16 to 24 year-olds disapproved of a married person having sex with someone other than his or her partner. In contrast to Furnham and Gunter (1989) almost 70 per cent of young males disapproved of male homosexuality, while the disapproval rate among females was substantially lower.

Because not much is known about the sexual attitudes of those living in China, a recent report based on the attitudes of Chinese youth is of considerable interest (Kaufman, Poston, Hirschl and Stycos, 1996). They surveyed over 5000 students in grades seven to twelve in Sichuan province and reported the following:

- Over 65 per cent of males and almost 80 per cent of females agreed or strongly agreed with sex before marriage.
- Almost 25 per cent of males and 17 per cent of females agreed that anyone has the right to use birth control measures to avoid pregnancy.

- Close to 45 per cent of males and females suggested that they would use birth control measures whenever they needed to.

Are there gender differences in attitudes to specific sexual behaviours? In one study (Wilson and Medora, 1990), over 600 university students in the USA were surveyed to determine their attitudes towards premarital sex, masturbation, homosexuality, extramarital sex, oral-genital sex, anal sex and sexual fantasising. Overall, both males and females approved somewhat of premarital sex when the couple is in love or engaged. They were also approving of oral-genital sex and sexual fantasising, although males and females disapproved somewhat of homosexuality and extramarital sex. There were, however, significant differences in attitude between the sexes. Males and females differed significantly on premarital sex for casual couples, extramarital sex, oral-genital sex and anal sex. On all of these, males reported more favourable attitudes. The findings are summarised in Table 7.1.

BEING IN LOVE

Most adolescents report their first experience of being in love around age 12 years, although there is a tendency for this to increase among students in the higher grades (Montgomery and Sorell, 1998). How do young people describe being in love? Perhaps not surprisingly, the

TABLE 7.1 *Attitudes of undergraduates towards sexual behaviour*

<i>Sexual behaviours</i>	<i>Mean scores</i>	
	<i>Males</i>	<i>Females</i>
Premarital sex – couple casually acquainted	2.90	3.76*
Premarital sex – couple in love	2.36	2.56
Premarital sex – couple engaged	1.89	1.99
Masturbation	2.96	3.16
Homosexuality	4.11	4.13
Extramarital sex	3.86	4.11*
Oral-genital sex	1.76	2.28*
Anal sex	2.80	3.36*
Sexual fantasising	1.66	1.79

Note: $n = 641$

*males and females differ significantly. Low scores indicate favourable attitude

Source: Wilson and Medora, 1990

themes that are touched upon vary quite considerably as shown by the following (Montgomery and Sorell, 1998, 683–4):

- Lack of experience and maturity. Some adolescents acknowledge that ‘real’ love only happens much later and that many adolescents are not mature enough for a relationship.
- What is love? Adolescents appear to have specific ideas on love vs. infatuation, love vs. sexual attraction, love vs. self-promotion, and love vs. loving (see Table 7.2).
- Love is friendship. Some see love as a stronger form of friendship.
- Love is mysterious; it is difficult to understand. For some, love is ‘confusing’, ‘complicated’, and ‘difficult to determine’.
- Love hurts. For a small number, love is a painful experience leading to no desire for further close commitments, at least for the foreseeable future.
- Reciprocity. It seems a small number of boys are incapable of ‘reading’ messages about the relationship from their partner.
- Love endures. A small number commented on the enduring nature of the experience.

THE SEXUAL TIMETABLE

Introduction to sexual intercourse appears to be a gradual process. Normally, adolescents first experiment with kissing and hugging before they proceed to ‘light’ and then ‘heavy’ petting (Harris and Liebert,

TABLE 7.2 *Adolescents’ perceptions of the true nature of love*

Love vs. infatuation

Most high school kids just say they are in love; they don’t know what ‘true love’ is

Love vs. sexual attraction

‘Being in love has nothing to do with sex’

Love vs. self-promotion

Teenagers in relationships are having them ‘for self esteem . . . or they do it for the challenge’

Love vs. loving

‘When you love someone you know about their faults and you realize that they may not be exactly as you want them to be, but you love them in spite of it’

Source: Derived from Montgomery and Sorrell, 1998, pp. 683–4

1987). There also appear to be racial and cultural differences in this regard. There is a developmental sequence from necking, to feeling parts of the body directly, to sexual intercourse for white 12 to 15-year-olds in the USA. Among blacks, however, fewer seem to engage in the various petting activities that precede intercourse (Miller and Moore, 1990). Rosenthal and Smith (1997) found age differences in the acceptance of sexual practices among Australian youth. Whereas only about 2–3 per cent of 12- to 14-year-olds thought that sexual intercourse was appropriate for them, among 15- to 17-year-olds the approval rate was much higher (approaching 65 per cent).

Adolescents are becoming sexually active at an increasingly younger age. This view is supported by a number of studies from different countries. For instance, a representative sample of Danish teenagers aged 16–20 showed that about one-third had experienced sexual intercourse by age 16 (Wielandt and Boldsen, 1989). Surveys of teenagers in the USA suggest that by age 15 years about half of black men had experienced sexual intercourse. For Hispanic-American men it was 16.5 years, while for whites it was 17 years. For black, Hispanic and white women respectively, the ages were 17, 18 and 18. For each racial group 90 per cent had experienced sexual intercourse by about 22 years of age (Michael et al., 1994). White American youth of both sexes report significantly more sexual partners over their lifetime than do Asian-American youth (McLaughlin et al., 1997).

Johnson and her colleagues (1994) surveyed the sexual attitudes and lifestyles of almost 20 000 Britains. Just over 4000 were aged between 16 and 24 years of age. The median age of first intercourse for women aged 55–59 years was 21, while for women aged 16–19 it was 17. Among older men the median age at first intercourse was 20, while it was 17 for younger men. Thus, there has been a consistent shift towards decreasing age for first sexual intercourse. British youth (16–24 yrs) also appear more promiscuous than those who are older (25–34 yrs). Among the younger group 11.2 per cent of males and 2.5 per cent of females had sex with 10 or more partners over the last five years. The figures for the older age group were 5.8 per cent and 0.8 per cent respectively. In Australia large-scale surveys of teenagers suggest that close to 50 per cent of Year 12 students have had sexual intercourse with lower rates for younger students (Lindsay, Smith and Rosenthal, 1997).

For many teenagers first intercourse can usually be described in one of the following ways (Mitchell and Wellings, 1998):

- It is unexpected – this is usually so for younger teenagers.

- It is not anticipated, but it is not a shock – in hindsight, both sexes are able to recognise cues that sex was always likely to occur.
- It is anticipated, but not wanted – in these cases negotiations about sex, if present, are usually very limited. Typically, the female succumbs to the male script. Later, women seem to express some ambivalence about what has happened.
- It is planned – these adolescents are older and in a steady relationship. For them sex is the next logical step in the development of their relationship.

INFLUENCES ON SEXUAL BEHAVIOUR

How do teenagers first learn about sex? Is the motivation to engage in sexual intercourse due to hormonal influences, or do social factors such as the influence of family and friends play an important role in shaping adolescent sexual behaviour? Let us consider some of these issues.

The Role of Family and Friends

Numerous studies have examined the relative effects of family and friends on adolescent sexual behaviour. Although both factors are important socialisation influences (Miller and Moore, 1990), it has been argued that the family sets the social context within which the adolescent will learn about sexuality (Tucker 1989, p. 270). Factors such as mother's adolescent sexual experience, the educational level of parents, the sexual activity of older siblings, communication within the family and parents' attitudes and values towards adolescent sexual intercourse have all been linked to the sexual behaviour of adolescents. Thus, for example, it has been found that early sexual experience of an adolescent mother may increase the likelihood that her adolescent daughter will also engage in sexual intercourse at a relatively young age.

Not all research supports the importance of family factors on adolescent sexual behaviour. A study of white and Asian American youth (McLaughlin et al., 1997) found that family factors (for example, perceived parental warmth and acceptance) were far less important as predictors of early sexual behaviour than factors such as the adolescent's perceived level of physical attractiveness and success in forming romantic relationships. One exception was noted among white females. Family conflict in decision-making predicted sexual activity for this group.

Parents' *marital status changes* determine adolescents' transition to sexual behaviour. Teenage males and females incorporate family structure and family disruption in different ways as manifest in their transition to sexual activity. On the basis of a longitudinal study among several hundred white teenagers in the USA, it was found that girls who remained in intact families had a 15 per cent chance of beginning sexual activity. Girls who moved from intact families to single-mother families increased their risks of sexual activity to 31 per cent. Boys who remained in intact families had a 24 per cent chance of beginning sexual activity, while boys who moved to single-mother families were much more likely to initiate sexual activity (a 70 per cent chance) (Newcomer and Udry, 1987).

Boys *remaining* in single-mother families only had a 25 per cent chance of being sexually active by Time 2, which leads one to conclude that it is the *disruption* of family life rather than the *type* of family which is an important predictor for male adolescents. Among girls, moving into blended families appears especially risky for the initiation of sexual behaviour, while girls *remaining* in single-mother households had a 38 per cent chance of being sexually active by Time 2. This leads one to conclude that the break-up of the family unit, rather than its type, is the important key to understanding adolescents' transition to sexual behaviour. It is quite likely that during marital or family break-up, partners are too concerned with their own personal problems to adequately supervise their children. It is also likely that single mothers (most of whom have custody), are sexually active and dating men, thus providing a particular role model for their adolescents. Newcomer and Udry (1987) concluded as follows: 'For boys the loss of control is associated with the disruption inherent in the loss of the father from the household, while for girls the loss of control is associated with the state of not having a father in the household and not the disruption per se'.

Single fathers who have custody of their teenagers are also presumably sexually active. Because most children reside with single mothers, few research studies have examined the sorts of role models that single fathers provide for their adolescents.

Parent-adolescent Communication

Several studies have highlighted the importance of parent-adolescent communication on the sexual behaviour of teenagers (for example, Jaccard and Dittus, 1991; Rosenthal, Feldman and Edwards, 1998; Whitaker and Miller, 2000). Although family communication about

sexual matters is important not least because of the implications for health status, research evidence suggests that parents' communications may be less effective. The problem, as Rosenthal and colleagues pointed out (Rosenthal et al., 1998), is that such communication is nearly always about biology, rather than decision-making.

It would seem that the mother is the primary source of information regarding the menstrual cycle and contraception, at least as far as the daughter is concerned. Parents also appear to differentiate between their sons and daughters with respect to the *content* of their sexual discussions. For example, there are some matters of a sexual nature that fathers simply don't discuss with their daughters. On the basis of several research studies, Mueller and Powers (1990) summarised these differences in content, which are shown in Table 7.3. It is clear that mothers tend to discuss a whole range of issues with their daughters. With her son, a mother discusses matters related to sexual morals, bodily changes and birth. Fathers discuss birth and abortion as well as homosexuality with their sons, although fathers' discussions with daughters tend to be much more superficial. Thus, there appear to be specific 'gaps' in communication; gaps which appear much larger among younger rather than older teenagers (Pistella and Bonati, 1998).

TABLE 7.3 *Parent-adolescent communication about sex*

<i>Mother with daughter</i>	<i>Mother with son</i>
• Menstruation • Dating and boyfriends • Sexual morality • Conception • Sexual intercourse • Birth control • Bodily changes • Homosexuality • Abortion	• Sexual morals • Bodily changes • Birth
<i>Father with daughter</i>	<i>Father with son</i>
• Least intense and least intimate discussions about sex	• Birth • Homosexuality • Abortion

Source: Mueller and Powers, 1990

TABLE 7.4 *Communicating about sex: mother-teenager patterns*

<i>Characteristics</i>	<i>Communication style</i>				
	<i>Avoidant</i>	<i>Reactive</i>	<i>Opportunistic</i>	<i>Child-initiated</i>	<i>Mutually interactive</i>
Initiation	Neither	Mother	Mother	Teenager	Mother and teenager
Predominant communicator	Neither	Mother	Mother	Mother and teenager	Mother and teenager
Comfort level of mother	Very low	Low	Moderate	High	High
<i>Topics discussed:</i>					
Psychological issues	No	No	Yes	Yes	Yes
Non-penetrative sexual practices	No	No	No	Yes	Yes

Source: Rosenthal, Feldman and Edwards, 1998

What communication styles do mothers use when they communicate with their teenagers about sex? One research team (Rosenthal et al., 1998) enquired about the role that parents play, the nature, style and frequency of sex communication, and so forth. Five communication styles were uncovered: avoidant, reactive, opportunistic, child-initiated, and mutually interactive. These are shown in Table 7.4 where the major characteristics of each are also displayed. It is clear that, compared to the avoidant style, a wider range of topics is discussed in the mutually interactive style. Moreover, neither mother nor teenager in the avoidant group is likely to initiate a conversation about sex.

To conclude this section, little research has been done on parent-adolescent sex communication in single-parent families. Do fathers with whom adolescent daughters reside, for instance, provide the sex information that is usually provided by the mother in intact families? More research is needed in this area.

Influence of Friends

Adolescents' perceptions of peer norms and expectations about sexual behaviour as well as the behaviour of friends are important in predicting adolescent sexual activity. Boys are more likely to learn about menstruation from their friends than from their parents, while girls are more likely to learn about menstruation from their mothers and friends

RESEARCH HIGHLIGHT 7.1

How communication by parents and peers influences adolescent sexual behaviour

Whitaker and Miller, 2000

These authors were interested in the communications that teenagers have with their parents and peers about sex. More particularly, they were interested in the joint effects of these different communications on sexual behaviour. Their participants were over 900 teenagers at risk for contracting HIV. It was found that those teenagers who talked with their parents about sex were more likely to initiate sexual activity later rather than earlier and were also more likely to have fewer partners. If peers were perceived to be engaging in sex early, this was likely to increase the chances of the participants engaging in sex. It was also found that peer norms to engage in sex were greatest on those teenagers who tended not to talk with their parents about sex. Teenagers who discussed condom use with their parents were more likely to use condoms, while this trend was strengthened in those teenagers who talked with their parents about condoms compared to those who did not.

than from their fathers (Amann-Gainotti, 1986; Mueller and Powers, 1990). Other sources of sex-related information include school nurse, doctor, television, radio, movies and magazines (Pistella and Bonati, 1998).

It would seem that, in many instances, peer group pressure rather than parental norms and values is an important factor in the adolescent's *decision* to engage in intercourse for the first time. Indeed, there is evidence of a close relationship between reported sexual behaviour of adolescents and their friends, although it has been suggested that the importance of how friends are perceived may be overstated (Smith, Udry and Morris, 1985). It could be that peer influence *interacts* with pubertal development in determining teenage sexual behaviour (see pp. 158–61).

Once adolescents are sexually active, it would seem that parental views are important as far as the continued use of contraception is concerned. Parents who are tolerant of adolescent sexual activity are

more likely to have adolescents who use contraception. Adolescents with more tolerant parents are less likely to experience stress about engaging in sexual intercourse, and are therefore more likely to use contraception (Baker et al., 1988).

Hormonal vs. Non-hormonal Influences

According to one viewpoint, an increase in sexual activity during adolescence is not learned, but is rather the result of uncontrollable endocrinological influences (Paikoff and Brooks-Gunn, 1990; Udry et al., 1985). Endocrinological changes occurring during puberty are the result of two processes. These are *adrenarche*, by which androgens are produced, and *gonadarche*, by which the hypothalamic-pituitary-gonadotropin-gonadal system is reactivated (Paikoff and Brooks-Gunn, 1990). Not only do these changes in endocrinological levels have the capacity to lead to early sexual intercourse, but they have also been used to explain other changes in behaviour and mood (Buchanan, Eccles and Becker, 1992; Paikoff and Brooks-Gunn, 1990).

Changes in hormone level can affect adolescent behaviour in four possible ways (Buchanan et al., 1992).

- First, hormone levels simply rise in concentration and have a direct and overwhelming impact upon behaviour.
- Secondly, it is possible that, as hormone levels rise (notably sex steroids and gonadotropins), the adolescent adapts by adjusting behaviour.
- Thirdly, it is possible that there are 'irregular' effects. In other words, the rise in hormone levels could be inconsistent or spasmodic, resulting in mood swings and rapid changes of behaviour.
- Finally, each of these factors may interact to varying degrees with one another, as well as with numerous social factors (for instance, family, peer and school relations) in influencing behaviour.

The view that early sexual activity, notably intercourse, is determined primarily by hormonal influences is not endorsed by all social scientists. Psychologists with a more psychoanalytic bent have tended to explain behavioural change during adolescence by focusing on the individual's internal drives. A range of emotional conflicts, sexual instincts, and Oedipal complexes motivate the adolescent to engage in various 'deviant' behaviours, ranging from compulsive eating to sexual intercourse (Buchanan et al., 1992).

RESEARCH HIGHLIGHT 7.2

The psychological factors associated with sexual behaviour
Cooper, Shapiro and Powers, 1998

Cooper and colleagues recently demonstrated that the causes and correlates of sexual behaviour among young people are quite complex. There is no single reason as to why adolescents engage in sexual behaviour. Rather sexual behaviour serves a wide range of psychological functions including (1530):

- enhancing physical and emotional pleasure;
- coping with negative outcomes;
- achieving intimacy with a particular person;
- gaining the approval of others and avoiding censure.

The authors developed a measure of these major domains which, when factor analysed, yielded the following components: enhancement, intimacy, coping, self-affirmation, partner approval, and peer approval. What is noteworthy is that these components were later found to be linked in logical and predictable ways with certain personality traits. For example, neuroticism was significantly positively associated with high scores on the coping, self-affirmation, and partner/peer approval sub-scales. Thus, the emotionally unstable were in greater need of self- and partner-approval.

There are racial and cultural differences in the extent to which adolescents engage in sexual intercourse (Miller and Moore, 1990). This suggests that other non-hormonal factors are also important in understanding why adolescents engage in sexual intercourse. Some researchers (for example, Paikoff and Brooks-Gunn, 1990; Brooks-Gunn and Furstenberg, 1989) suggest that, even if hormonal effects on sexual behaviour are clearly demonstrated, one still needs to consider the effects of social and other contextual factors. They argue that hormonal and non-hormonal factors interact in a variety of complex ways to produce behaviour.

Acknowledging the importance of non-hormonal factors, it has been argued that a biosocial model is most useful for understanding adolescent sexual behaviour (Udry, 1988). Both biological and social factors are important in predicting whether adolescents will engage in early

sexual intercourse. Hormonal factors act as social signals, heralding that the adolescent is now physically ready to engage in sexual activity. However, a variety of factors co-determine the propensity of a teenager to engage in intercourse. Included are motivation (hormones, libido, etc.), physical attractiveness and social control (restrictions, familial controls, opportunities, etc.) (Udry and Billy, 1987) and other psychological factors (see Research Highlight 7.2). Research has shown that early maturing girls (a biological influence) are much more likely than other girls their age to have older friends who, it is believed, will increase the risks of early initiation into sexual activity, smoking, and possible drug use (Brooks-Gunn and Furstenberg, 1989).

The biosocial model was tested among a large sample of teenagers in the USA (Udry and Billy, 1987). The respondents were asked a wide range of questions about their behaviour and attitudes, while parents and friends were asked to rate the teenagers on various behavioural and other dimensions. Important sex and race differences were observed. For example, social controls were not as important in predicting sexual intercourse for white males and black females, while the sexual behaviour of white males was found to be strongly related to hormonal effects (namely androgens). There was, however, a strong social effect for white females with their non-coital sexual behaviours being determined by androgenic hormones. It was also found that white females who participated in sports and had a father living at home were less at risk for early sexual intercourse than others. An important predictor for black females' transition to sexual intercourse was attractiveness. In addition, black girls were found to engage in sexual intercourse at an earlier age than their white counterparts, although the authors are at a loss to explain this.

Results such as these lend support to the biosocial approach to understanding sexual behaviour among adolescents. Not only are hormonal levels important, but they also interact with social factors in unique and important ways. Udry and Billy (1987, 852) concluded that:

The effects of hormones on males' behavior are much stronger than on females because, as males mature, their androgen levels go up by a factor of 10 to 20, while, in females, androgen levels hardly double, with males and females starting from the same prepubertal levels. In males, the hormone levels may overwhelm the social controls.

Further support for the biosocial approach comes from a study by Smith, Udry and Morris (1985). They found that increased sexual motivation among a sample of teenagers was related to levels of puber-

tal development as well as the sexual activity of best friends. Thus, there was an important interaction effect between the social and biological factors, which influence sexual behaviour. Smith and colleagues concluded that research that ignores the contribution of biological factors may be overstating the effects of social factors.

CONDOM USE AND THE THREAT OF AIDS

Contraception has traditionally been important in the context of adolescent pregnancy. Although teenage pregnancy continues to be of major concern, the focus has shifted somewhat in recent times. With the advent of the AIDS crisis, one particular form of contraception, namely condom use, has become the focus of renewed research attention and is considered to be paramount in the prevention of HIV infection and other sexually transmitted diseases (STDs).

Female adolescents have among the highest rates of gonorrhea, cytomegalovirus, chlamydia cervicitis and pelvic inflammation (Brooks-Gunn and Furstenberg, 1989), while black teens in the USA have higher rates than Hispanics or whites (Buzi, Weinman and Smith, 1998;

RESEARCH HIGHLIGHT 7.3

Ethnic differences in STDs in the USA

Buzi, Weinman and Smith, 1998

205 female adolescents who attended health clinics in Houston, Texas, were screened for STDs. Of the sample, 72.7 per cent were black, 9.8 per cent were white, and 17.6 per cent were Hispanic. It was found that:

- white teenagers had more sexual partners than either blacks or Hispanics;
- blacks, but not whites or Hispanics, were more likely to present with syphilis;
- the most frequent infections for the whole group, on a percentage basis, were chlamydia (50.2), trichomoniasis (32.2), gonorrhea (10.2), condyloma (10.2), syphilis (6.3), herpes (4.9), and lice (2.4).

see Research Highlight 7.3). These diseases are likely to be exacerbated by early sexual activity and inconsistent condom use. Thus it has become imperative that adolescents be educated about the risks of 'unprotected' sex; indeed, failure to reduce risky sexual behaviour among adolescents may dramatically increase the number of adolescents diagnosed with STDs or as HIV-positive.

Survey results suggest that condom use by adolescents has been steadily rising. In Britain, teenagers are now much more likely to use condoms or the pill than other forms of contraception (Johnson et al., 1994). Although rates of condom use have risen sharply in recent times, they are still relatively low (Brooks-Gunn and Furstenberg, 1989), and vary between ethnic and racial groups (Strunin, 1991). Many adolescents seem to be apathetic and irresponsible about condom use and the risks associated with unsafe sex. Indeed, one Australian study found that 83 per cent of respondents agreed that condoms generally prevent the spread of AIDS and STDs (Barling and Moore, 1990). However, only 38 per cent of them also agreed that AIDS was something they had not thought a lot about, while 30 per cent felt that it was of no concern to them, since their best friends were unlikely to be HIV-positive.

There are two major theoretical approaches to understanding contraceptive behaviour among adolescents. These are cognitive or decision-making models and socialisation models (Balassone, 1991). Let us briefly review the role of cognition.

The Role of Cognitive Factors

The practice of contraception among sexually active adolescents has been quite firmly linked to cognitive development and various aspects of formal reasoning (Gordon, 1990). In the first instance, it would appear that some adolescents do not comprehend the different forms of contraception that are available. Secondly, some do not properly evaluate the consequences of their actions so that, quite often, the pregnancy is 'unexpected' and unanticipated. Furthermore, it is clear that some adolescents do not take their partner's needs into account with some males failing to appreciate the risks of pregnancy to their female partners (Gordon, 1990, 348–9), while 'adolescent females may romanticize their boyfriends' position by perceiving unprotected intercourse as an affirmation of love and commitment to a relationship'.

Evidence also indicates that some adolescents cannot adequately reason about chance and probability. In other words, these teenagers seem to think that a single act of unprotected intercourse is less risky

than several such acts. Again, they appear quite surprised at the 'unexpected' pregnancy or infection. Such deficits in cognitive functioning have been referred to as *global developmental delay*. These teenagers also very often underachieve at school, which may be suggestive of an environment that is deficient in opportunities for abstract thinking (Gordon, 1990).

Teenagers make decisions about contraception in different *social contexts* and these need to be taken into account when predicting condom use. Thus, adolescents' perceptions about risk and responsibility for pregnancy as well as their subjective feelings about embarrassment are important factors in contraceptive decision-making.

In a survey of almost 2000 15 to 19-year-old males in the USA, it was found that normative beliefs predicted condom use, that is, males who believed it is the male's responsibility to prevent pregnancy were more likely to use them (Pleck, Sonenstein and Ku, 1991). Their *personal* concerns about pregnancy were found to be less important. In other words, concern about fathering a child *per se* was less important than normative beliefs about pregnancy prevention. Males who believed that their partner was not using the pill were also more likely to use a condom. In addition, frequency of worry about AIDS, rather than actual perceived risk of HIV infection, was more likely to lead to condom use. Males who perceived their partner as wanting them to use a condom, and as being appreciative of this, were more likely to use one. On the

TABLE 7.5 *Males' costs-benefits of condom use*

Preventing pregnancy: personal costs-benefits

- Concern about pregnancy increases condom use
- Belief that female uses pill reduces condom use

Preventing pregnancy: normative belief

- Belief that males have responsibility for reducing pregnancy increases condom use

Avoiding AIDS

- Concern about AIDS increases condom use

Partner expectations

- Request by females raises condom use
- Belief by females that they can get males to use condoms increases use

Embarrassment and reduction of pleasure

- Perception of not being embarrassed increases condom use
 - Belief that sexual pleasure will not be negatively affected increases condom use
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Source: Pleck, Sonenstein and Ku, 1991

other hand, males' embarrassment or belief that pleasure would be reduced was likely to reduce condom use (see Table 7.5).

Not all males will suggest using a condom during sexual intercourse; very often it may be up to the female to suggest some form of contraception. Others might not even discuss the question of contraception, and appear to blatantly disregard the risks of pregnancy and STDs. It is this attitude of denial and irresponsibility which led Moore and Rosenthal (1991a) to comment as follows (164): 'Adolescents are reputed to be highly susceptible to this kind of thinking, that is, the illusion that although others may suffer the consequences of dangerous and risky actions they are somehow immune.'

Risky Sexual Behaviours

There would seem to be a discrepancy between adolescents' knowledge of safe sex and their actual behaviour. A survey of undergraduate non-virgins (mean age = 18.5 years) found that almost 10 per cent were engaging in unprotected vaginal intercourse with casual partners, while 15 per cent were engaging in withdrawal. Among regular partners, the frequencies were 13 and 27 per cent respectively (Rosenthal, Hall and Moore, 1992). Thus, some teenagers are engaging in more risky behaviours with partners described as 'regular'. One study of adolescents attending community-based agencies in New York and Los Angeles found that females were more likely to engage in unprotected sexual behaviours, while males reported having had more partners (Murphy, Rotheram-Borus, and Reid, 1998). The situation seems more critical among those young people who present themselves to clinics for the detection and treatment of STDs. These youth, it would seem, are much more likely to engage in unprotected vaginal sex (57 per cent of cases) (Heffernan, Chiasson and Sackoff, 1996).

Although it appears that Hong Kong adolescents have relatively low levels of risky behaviours (Davis et al., 1998), there is very little discussion about HIV/AIDS and related issues: 85 per cent of respondents had not discussed HIV/AIDS with their family, while 60 per cent had rarely or never raised this problem with their friends. Instead, most information was derived from television and newspapers. Moreover, about 15 per cent of the sample believed that Westerners were more at risk of contracting HIV/AIDS than Asians and that the disease was really a problem for IV drug users, homosexuals, and prostitutes.

Attitudes to AIDS precautions are linked to the likelihood of engaging in risky sexual behaviour. Moore and Rosenthal (1991b) in

Australia found that females were more positively disposed to AIDS precautions than were adolescent males (see also Parsons et al., 2000). Females with negative attitudes to precautions were more likely to engage in risky sex. Males with a more fatalistic attitude towards AIDS and those with multiple partners were more likely to engage in risky sexual behaviour (Moore and Rosenthal, 1991b).

Finally, which factors best predict whether young gay men will practise safer anal sex? The following were found in a study of 100 young gays attending a community centre (Rotheram-Borus et al., 1995):

- a perception of being susceptible to the HIV virus,
- possessing positive attitudes to safer sex,
- having perceptions of greater self-efficacy,
- greater self-control in sexual situations.

Are there particular personality traits that discriminate those that engage in safer sex from those who do not? Evidence indicates that a link exists between personality disposition and the likelihood of engaging in risky sexual practice. Important factors are beliefs about personal control and self-efficacy (Joffe and Radius, 1993; Moore and Rosenthal, 1991a). Moore and Rosenthal found that only 6 per cent of the late adolescents in their study thought that they could *moderately* control their chances of getting AIDS, while 17 per cent thought they could *completely* control them. It was also found that belief in personal control was related to various types of sexual behaviour such that a perception of low personal control accompanied moderate- to high-risk sexual behaviour. In other words, adolescents who took a more fatalistic approach to diseases such as AIDS were less likely to employ safe sex strategies.

The importance of a sense of control has been alluded to in several other reports. Females are especially at risk for HIV infection as they are less likely to insist on condom use with regular partners than with casual ones. Thus, females tend to shift the burden of responsibility (or control) on to their partners. Male respondents tended not to distinguish between casual and regular partners, perhaps because they view HIV infection largely as a problem for homosexuals rather than heterosexuals (Crawford, Turtle, and Kippax, 1990).

How is one to understand these findings? One argument is that females are *traditionally* more dependent and less proactive in sexual matters than are many males (Heaven, Connors and Kellehear, 1992). For example, males may be relatively more comfortable with the practice of buying condoms (or asking for them from a clinic) as a preventive

RESEARCH HIGHLIGHT 7.4
Denial and the risks of HIV/AIDS
 Ben-Zur et al., 2000

HIV/AIDS denial increases the chances of not engaging in safe sex and thereby contracting the disease. The following are likely to occur:

- Denial prevents the accumulation of appropriate knowledge.
- Denial helps strengthen negative attitudes and strengthens barriers to buying condoms.

measure in sex. This attitude is probably less common among females. Traditional sex roles that encourage males to be active and females to be passive and supportive in dating and sexual practices may predispose females with a lower sense of control to take less preventive measures against risk of infection. Indeed, as Seeman and Seeman (1983) found, lower sense of control may also be associated with less self-initiated preventive care.

Implicit Personality Theories and Risky Behaviour

A question that often arises is why adolescents engage in risky sexual behaviours even though they are knowledgeable about HIV transmission. An important qualitative study using focus group discussions found that college students use *implicit personality theories* when judging the riskiness of potential sexual partners. As summarised in Table 7.6, respondents use several strategies to judge the HIV status of partners. The risks that these students run is that these constructions of another's HIV status are likely to be incorrect, uninformative, and unreliable – and can prove fatal (Williams et al., 1992).

ADOLESCENT SEX OFFENDERS

It has been reported that about 20 per cent of all rapes and some 30–50 per cent of all child sexual abuse cases are committed by adolescents (Davis and Leitenberg, 1987). Alarming as these statistics are, the authors suggest that they may, in fact, under-represent the true picture.

TABLE 7.6 *Implicit personality theories used in judging HIV status of potential partners****Judgements of riskiness of sexual partners***

- 1 Known and liked partners are viewed as not risky: ('I knew my partner really well before we had sex, so I didn't have to worry about her sexual history').
- 2 Risky people dress provocatively, hang around bars, tend to be older, are from large cities, and are keen for sex: ('If they're dressed up like a slut . . . they're usually a slut').
- 3 Respondents tend only to use condoms with partners they don't know well: ('If you just met, then you use a condom . . . if it's long term you aren't going to worry').

Assessments of personal risk

- 1 Respondents often thought themselves generally not at risk: ('Personally, I'm not really worried about AIDS on this campus').
- 2 Respondents feel personally not at risk: ('I'm not gay').

Reasons for unsafe sex

- 1 Alcohol
- 2 Lust: ('In the heat of the moment you don't think about it [AIDS]').

Beliefs about condoms

- 1 Condoms interfere with sex;
- 2 they are unpleasant to use;
- 3 they are inconvenient;
- 4 they have undesirable implications – that is, you don't trust your partner.

Source: Williams et al., 1992

As they point out, not all offences lead to convictions and not all victims and their families report assaults. This may be because, very often, the offender is known to the victim and the family. Indeed, some parents may even regard the incident as 'insignificant', thinking of it as mere 'sexual exploration' and 'experimentation'.

Most adolescent sex offenders are male. Studies reveal that the most common offence is fondling ('indecent liberties') accounting for about 59 per cent of cases. This is followed by rape (about 23 per cent of cases), exhibitionism (11 per cent), and other non-contact offences (for instance, indecent phone calls, 7 per cent). Assaults against similar-age adolescents or those who are older usually involve rape (67 per cent of offences). Among younger children, however, rape only accounts for 24 per cent of offences (Davis and Leitenberg, 1987).

According to many reports, victims are often known to the offender. In one study of incarcerated adolescents, for example, it was found that in 55 per cent of cases the victim was known to the offender in some way. Moreover, child victims rather than older ones are more likely to be known to the offender. Indeed, very often victims may be family members (20 per cent in one report; Davis and Leitenberg, 1987).

Sex offenders also manifest other behavioural and adjustment deficits with many adolescent sex offenders having also been charged or convicted of other delinquent offences.

Adolescent sex offenders can usually be described in terms of a particular family history, social and psychological maladjustment, and a record of physical and sexual abuse. One study found adolescent sex offenders, compared with non-offenders, to be socially isolated, to engage in assaults more frequently and to be more resentful (Valliant and Bergeron, 1997). Steele and Ryan (1991) elaborated on some of the family and personal characteristics of juvenile sexual offenders. Their life histories share many common themes such as lack of empathic experience and lack of available coping models. Some families display low levels of affect, and greater family secrets and distorted attachments, while the offender's role in the family appears to be as a focus for others' guilt and shame (Ryan, 1991). Sex offenders may also show less emotional bonding to peers and be estranged in their relations with others. Quite often the mother-son relationship of these boys shows poor levels of communication with the families being described as 'dysfunctional' (Blaske et al., 1989).

As females do not commit many adolescent sex offences, there is a dearth of research in this area. One exception is a report by Fehrenbach and Monastersky (1988). According to their observations, sexual offences among females do not form part of a syndrome of delinquent behaviour, as so often seems to be the case with boys. Most offences are against a younger victim who, more often than not, is someone known to the offender. Whereas a large proportion of male offenders commits acts of exhibitionism, indecent phone calls, and so forth, this does not appear to be the case among female offenders. Finally, whereas male offenders quite often have a history of physical or sexual abuse, this tends not to be a causative factor for female offenders. As the authors note (Fehrenbach and Monastersky, 1988, 151): 'prior sexual abuse alone does not explain why a girl would become an offender. Many more girls than boys are sexually abused as children, yet most offenders are male.'

ADOLESCENTS IN PROSTITUTION

Juvenile prostitution has shown a steady increase over recent years. It is estimated that in the ten-year period, 1970–80, juvenile prostitution increased from 24 to 74 per cent in New York City (Schaffer and

DeBlassie, 1984). Large increases have no doubt also occurred in all other large cities across the world. Of concern are the enormous physical and emotional risks involved, such as rape, murder, STDs including HIV infection, and pornography. In some developing countries where control of prostitution is less effective, STD rates are almost 50 per cent in brothels with condom use being very low (Joesoef et al., 1997).

Social scientists have speculated on the reasons for adolescent prostitution. The following have been suggested (McMullen, 1987; Schaffer and DeBlassie, 1984):

- alienation from the family, rejection by the family;
- parental abuse (psychological, sexual, physical and spiritual);
- limited employment opportunities for lower class women, some teenagers might also be attracted to prostitution through economic need;
- a sense of hostility (for example, anger at being rejected by their family), a sense of adventure and drug abuse.

Because of their age, adolescent prostitutes are relegated to the streets, and tend not to work in hotels and parlours. Most are under supervision of a pimp who, in a limited number of cases, might provide a sense of security and some shelter (Schaffer and DeBlassie, 1984). Although young male and female prostitutes may be in prostitution for similar reasons, they also differ in some very important ways. Whereas female prostitutes engage in heterosexual intercourse, most male prostitutes participate in sex with other (usually older) males, even though they would normally regard themselves as heterosexual (Schaffer and DeBlassie, 1984).

SEXUAL ORIENTATION

Although this chapter has focused chiefly on heterosexual relationships, a relatively large proportion of teenagers will, at some stage, adopt a homosexual orientation. It has been estimated that up to one-third of male adolescents beyond 16 years of age have had at least one homosexual experience up to orgasm (Miller and Dyk, 1993).

There is some doubt as to whether a homosexual orientation can be established or identified in adolescence (for example, Remafedi, 1987; Savin-Williams, 1991). According to this view, homosexual experience is part of normal sexual experimentation and growing up. Any inclination to be attracted to someone of the same sex, it is argued, will in most

cases be outgrown. Glasser (1977) asserts that it is only possible to be labelled gay or lesbian *after* adolescence. According to this view, there is very little relationship between homosexual experience during adolescence and self-description as a homosexual during adulthood.

Is it possible to identify a homosexual orientation in the teen years? Although many adolescents may not directly label themselves as gay or lesbian, it is possible that they experience a feeling of 'being different' and of being attracted to others of the same sex. This can be a time of great confusion for these teenagers whose desires are at odds with the heterosexual world in which they live. Very often they are not able to understand their inner feelings, which run counter to general social norms and expectations. Among these youth, the label homosexual, gay or lesbian is only used later (around 19 years of age). It is not until some years later (around 23–28) that many will disclose their homosexual orientation to significant others (Remafedi, 1987). It is perhaps only a very small proportion of young teenagers who actually label themselves as homosexual, but this can occur as young as 14 years of age (Remafedi, 1987).

It has been reported (Garnets and Kimmel, 1991) that males and females are first aware of being erotically attracted to members of the same sex at different ages. For males, this can occur between the ages of 12 and 13, while for females it can happen between 14 and 16. Garnets and Kimmel (1991) suggest the following developmental milestones for homosexual identity development:

- initial awareness of same-gender affectional-erotic feelings – around 12–16 for gays and lesbians,
- initial same-gender sexual experience – earlier for gays (about 14 years) than lesbians (about 20 years),
- self-identification as lesbian or gay – late adolescence/early adulthood for both gays and lesbians,
- initial same-gender sexual relationship – early adulthood for both gays and lesbians,
- positive gay or lesbian identity – mid to late 20s.

The awareness of being attracted to others of the same sex can, for some, be a traumatic experience. Very often there is no one in whom to confide – least of all friends and parents. These teenagers' sexual urges do not fit with social or personal expectations. They are often very confused and suffer emotional distress. This may have a negative impact on school performance, and emotional upheaval may also lead to other behavioural problems, such as loneliness, suicide ideation, victimiza-

tion, violence, drug and alcohol use, and running away from home (see Faulkner and Cranston, 1998; Martin and Knox, 1997).

There seems to be a growing awareness of, and openness to, different sexual orientations. Discrimination against people on the basis of sexual preference has been outlawed in some countries, and gay support groups have been established in many centres. Compared with previous generations, society seems more accepting of gay people, and it is now much easier for gays and lesbians to come to terms with their own sexuality and 'come out'.

Should one attempt to modify the behaviour or attitudes of an adolescent who 'comes out' or is suspected of being gay? Most writers would say no. Although techniques for behaviour change were attempted in the 1950s and 1970s, their effectiveness was always disputed. As Remafedi (1991, 505) explains: 'conventional wisdom suggests that sexual orientation is resistant to change and that attempts to change should be resisted, so as not to compound identity confusion, shame, and intrapsychic injury.'

THEORETICAL CONSIDERATIONS

Although few researchers actively set out to test the major theories as described in Chapter 1, three relate to the work examined in this chapter. These are biological theory, Erikson's identity formation theory and cognitive development. There is clear evidence that biological changes occur during puberty. These take on various forms, including endocrinological and physical changes. They have an impact not only on the teenager's emotional state (for example, moodiness or depression), but also on parent-child relationships and sexual behaviour. Research evidence points to the influence of both hormonal and non-hormonal factors on sexual behaviour.

Synonymous with adolescent sexuality is identity formation. With biological change comes an awakening of sexual feelings and urges, an awareness of a sexual force within the adolescent. It is both exciting and intriguing and, at first, shrouded in mystery. An important developmental task is the exploration of this new dimension of the self and the discovery of just who one is sexually. Sexual identity cannot be divorced from one's self-identity, and in this regard, a loving and supportive family is important in facilitating self-discovery.

During the adolescent years, the teenager is undergoing cognitive development. As we noted, this has implications for sexual

decision-making. Younger adolescents, it seems, are less able to reason about risk and probability and are therefore more likely to engage in sexual behaviour regarded as risky for HIV infection and pregnancy.

SUMMARY

In this chapter we considered some important issues relating to adolescent sexuality. From the evidence reviewed here, it is clear that adolescents are engaging in sexual intercourse at an increasingly young age. Sexuality is an important issue affecting all adolescents, and it was argued that they must come to terms with their own sexuality and incorporate it into their self-identity with as little disruption as possible.

This chapter reviewed findings that point to the importance of hormonal and non-hormonal factors (particularly the influences of family and peers) in explaining why some adolescents become sexually active. It seems clear that hormonal factors alone cannot explain sexual behaviour among adolescents and that a range of non-hormonal ones may need to be considered as well. Some reports have suggested that hormonal and non-hormonal factors interact in complex ways in determining adolescent sexual behaviour.

AIDS is a major crisis which all of us, including adolescents, must confront. Unfortunately, many adolescents seem unperturbed by the risks of unprotected sex. Indeed, many appear irresponsible. According to some reports, many adolescents do not practise safe sex and are putting themselves at risk for HIV infection and other STDs. Although adolescents appear knowledgeable about safe sex strategies, this is not matched by their behaviour.

Of further importance is the observation of links between risky behaviours and attitudes to AIDS precautions and certain personality traits. Those adolescents adopting a more fatalistic attitude are more likely to engage in risky behaviour and therefore increase their risk of HIV infection. Future research should concern itself with how all adolescents might be encouraged to change their behaviour and adopt safe sex practices.

ADDITIONAL READING

Brooks-Gunn, J. and Furstenberg, F. (1989) 'Adolescent Sexual Behavior', *American Psychologist*, 44: 249-57.

- Cooper, M. L., Shapiro, C. M. and Powers, A. M. (1998) 'Motivations for Sex and Risky Sexual Behavior among Adolescents and Young Adults: A Functional Perspective', *Journal of Personality and Social Psychology*, 75: 1528–58.
- Newcomer, S. and Udry, J. (1987) 'Parental Marital Status Effects on Adolescent Sexual Behavior', *Journal of Marriage and the Family*, 49: 235–40.

EXERCISES

- 1 The literature suggests that, although adolescents are aware of the risks of HIV infection, they tend not to practise safe sex. Can you think of some strategies to encourage sexually active teenagers to take precautions against HIV infection?
- 2 Replicate the Wilson and Medora (1990) study referred to in the chapter (see also Table 7.1). If you obtain similar findings, what can you conclude?