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Richard Wetzel

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Adolescent Sexuality and Chastity

Richard Wetzel, M.D.

Doctor Wetzel received his medical degree from Albany College in 1980. He has lectured widely and presently is instructor and developer of the Adolescent Sex Education Program for Olive Crest Treatment Center for Abused Children in Anaheim, California. The program is a seven week pro-chastity curriculum taught in the group home setting.

Having been involved in the area of adolescent sexuality for two years, I thought it might be appropriate for me to share with you, my fellow physicians, some ideas on the subject. I have been teaching a seven part series, on the chaste approach to sexuality, to teens with unstable, abusive backgrounds, who are currently living in group homes.

In light of this involvement, I recently attended a "Contraceptive Technology" conference in Anaheim, sponsored by Planned Parenthood and the California Family Planning Council. The experience inspired a few thoughts.

A panel discussion on adolescent sexuality was conducted at the conference and included two of the co-authors of the familiar text, *Contraceptive Technology*. During the discussion, one of the panelists dramatically asked for a show of hands in answer to the question, "What is *the* problem (when considering the general issue of adolescent sexuality)?" He offered three possible answers: teens involved in premarital sexual activity, teen pregnancy, or teens giving birth. The choice was unanimous among the "experts" on the panel: *the* problem was teens giving birth.

It is amazing that after two decades of having defined *the* problem as the teen pregnancy rate, suddenly the emphasis has been changed to the problem of teens giving birth. What prompted this magical change in emphasis?

The change is a result of a gradual realization by those in the field that the simplistic approach of giving teens contraceptives, in an effort to cure the complex problem of teen pregnancy, has failed. Since this approach has failed, and discussion of any other approach is intolerable for most of the recognized "experts", the problem has simply been re-defined.

How do we know that promotion of contraceptives to teens has failed to reduce the teen pregnancy rate? Two types of studies which have been

carried out offer answers. One type studies the influence of individual school-based clinics. The other is based on large-scale national surveys.

In the former, the effect of such contraception-promoting clinics has been measured, following achievement of utilization goals, at various high schools across the country. After 15 years' experience with such clinics, Planned Parenthood reported that ". . . there is no conclusive evidence showing that school-based clinic utilization lowers pregnancy rates . . ." (*Family Planning Perspectives*, 20:4, 1988).

Of the large scale national surveys, the definitive one was done by Melvin Zelnik and John Kantner from Johns Hopkins, who performed such surveys on adolescents from 1971-1979. I have not seen any confirmatory studies of such magnitude since. Their results are reported in a series of articles which appeared in Planned Parenthood's journal, *Family Planning Perspectives* (9:2, 1977, pp. 55-72; 10:1, 1978, pp. 11-20; 10:3, 1978, pp. 135-142; 12:5, 1980, pp. 230-238). They, too, were unable to demonstrate that promotion of contraceptives reduced pregnancy rates. Note: Planned Parenthood publishes *Family Planning Perspectives* through its research arm, the Alan Guttmacher Institute. Much of the research done in the field of adolescent sexuality is printed in this publication.

Additional Findings

Zelnik and Kantner's findings also include the following: There has been "an increase in the prevalence of premarital sexual activity (among teenagers, from 9 percent in 1971 to 16 percent in 1979). "Among all women with premarital sexual experience, there was an increase between 1976 and 1979 in the percentage who said that they had always practiced contraception (from 29 percent to 34 percent) and in the percentage who reported using a method at first intercourse though not always (from 10 percent to 15 percent); and there was a decline (from 36 percent to 27 percent) in the proportion who said that they had never used a method.

"Despite this evidence of increased and more consistent contraceptive use, there was a rise between 1976 and 1979 in the proportion of premarital pregnancies occurring among those who reported that they had always used a contraceptive method (from 10 percent to 14 percent) . . .

"Among always-users, the increase in premarital pregnancies may be partially due to this factor (a rise in the frequency of intercourse) as well as to a decline in the use of the most effective medical methods — the pill (most recent method used changed from 47.8 percent to 40.6 percent) and the IUD (most recent method used changed from 3.2 percent to 2.0 percent) . . .

This discouraging situation is highlighted by the fact that although nonuse of contraceptive methods has declined in recent years, the fall has not been sufficient to overcome the forces that are working to elevate pregnancy rates."

The year following publication of Zelnik and Kantner's conclusions, Planned Parenthood published a report entitled, "Teen Pregnancy:

The Problem That Hasn't Gone Away."

Explanation for the failure of contraception promotion to reduce the teen pregnancy rate is no doubt complex. There is little argument in the literature that contracepting teens are more sexually active than their noncontracepting counterparts. Also, teens are the least reliable contraceptors regardless of the method. These are likely the major reasons why the pregnancy rate does not drop appreciably in response to greater availability of contraceptives.

Admittedly, measurement of the effect of using artificial contraception on an individual's risk of pregnancy is difficult, and involves consideration of multiple unmeasurable variables. However, the issue has been researched intensively, and the studies have failed to document contraceptive efficacy among adolescents.

Dispensing Contraceptives Failed

Since dispensing contraceptives to teens has failed to solve the problem of teen pregnancies, we now hear that the problem really has been teen births, not teen pregnancy! Is this shift in emphasis, after so long, evidence of frustration over the failure of artificial contraception to solve the problem of teen pregnancies?

To say that teens giving birth is suddenly the major problem creates a whole new set of issues. For instance, does this approach imply that teen abortion is not a major problem, because that is how one prevents a "non-problematic" teen pregnancy from becoming a "problematic" teen birth? Are we to consider abortion an unexceptional, insignificant experience for a teenager?

Teen pregnancy is not a problem? What about the despair girls experience when their boyfriends vanish following disclosure of a pregnancy? What about the regret of having become so involved in the first place? And what about the higher rate of suicide among pregnant teens? The list of problems related to adolescent unwanted pregnancies is long and painful. To say it is not a considerable problem is outrageous.

Advocates of this new emphasis are unfortunately running away from the central issues. Instead of turning toward the source of the problem — the cause of teen pregnancy — they're focusing on just one of the many consequences of it.

These people should be admitting not only that teen births, teen abortions, and teen pregnancies are all major problems but that the antecedent to these problems, teen premarital sexual activity, is in itself a problem. It is the problem from which the others are derived. Such an admission, however, would contradict one of their basic premises — that teens having premarital sex is not a problem. For example, Faye Wattleton, president of Planned Parenthood, says: "We are not going to be an organization promoting celibacy or chastity . . . We've got to be more concerned about preventing teen pregnancies than we are about stopping

sexual relationships" (*L. A. Times*, Oct. 17, 1986).

Studies performed to determine why teenagers have premarital sex show repeatedly that teens are using each other through their sexual relationships — using each other to reduce their loneliness, to have a boyfriend or girlfriend, to be popular, to fit in because "everybody's doing it", to prove something, to escape depression or boredom, etc. Such motivations are self-serving and indicate that these children are willing to use others to achieve "needs" for themselves. They are involved in selfishly motivated sexual relationships instead of truly loving, selfless, healthy sexual relationships.

I ask sexually active girls in my classes and those in my office what would happen if they "just said no" to premarital sex with their current boyfriends. Invariably, they express concern that the relationship would end. How sad that they are so aware of the self-serving nature of their sexual relationships. I've found with the boys whom I've taught that they too are just as aware that they are using the girls or are being used.

Using others leads to suffering. Someone invariably gets hurt when one is used or abuses someone else. Teens involved in premarital sex suffer from their abuse of each other through guilt, fear, embarrassment, unwanted pregnancies, distrust, sexually transmitted diseases (STDs), depression, etc.

Source of Problem

If teen premarital sexual activity is a problem can we identify the source of that problem? Clearly we can. There is a strong association seen between teens involved in early or promiscuous sexual relations and low self-esteem or insufficient self-love. The lower a child's self-esteem or ability to love himself or herself, the greater the risk of becoming involved in the many activities so often found in association: premarital sexual activity (including prostitution), drugs, alcohol, academic decline, depression, smoking, crime, suicide, etc. Any adolescent psychiatric ward, adolescent chemical dependency unit, or juvenile hall is filled with such teens — teens who do not value themselves.

It is not surprising that such adolescents are willing to use each other sexually. Such a willingness derives from the outspoken despair expressed today. We hear, "Who cares?" "It doesn't matter," "Life sucks and then you die." As Bob Seeger sings about "awkward teenage blues" in the song "*Night Moves*," "I used her, she used me, and neither of us cared."

But worse, when low self-esteem leads to premarital sex, there often develops a vicious cycle. How do teenagers feel about themselves, knowing that they're using someone or being used? How do they feel about themselves when they get themselves or someone else pregnant or get a disease? How do they feel about themselves when they have an abortion or tell their girlfriend to have one? Teen premarital sexual activity leads to more problems, more guilt, more fear, more embarrassment, more distrust, more depression and hence, even greater loss of self-esteem. The children

become even less able to love themselves or life.

Increasingly discouraged, the most tragic cases become so involved in self-destructive behaviors that they achieve the ultimate in self-destruction, death. It may come by motor vehicle accidents, suicide, AIDS, criminal involvement, or other circumstances related to drug abuse, etc. At some point the most unfortunate adolescents lose all interest in life or self-preservation. We've all seen such teenagers — teens who just don't care anymore.

A central issue, then, in the area of adolescent sexuality is lack of self-esteem. This often prompts, among other things, teen premarital sexual activity, which further exacerbates the original problem. To break this cycle, should we continue to concentrate our efforts on offering students easy access to contraceptives, an approach which leads to greater promiscuity and subsequent abuse, or should we be promoting premarital abstinence?

Through rarely discussed, the greatest boost to an adolescent's self-esteem probably comes simply from doing good, from offering themselves to others. We must encourage adolescents, especially those in trouble, to love others in the purest sense of the word, in the sense of the Golden Rule. Such a love is respectful, responsible, disciplined, committed and honest.

As has been said, "It is in giving that we receive", and so it is that in loving others we learn to love ourselves. Those who do good are lovable and usually know it. So being good is its own reward. It boosts one's self-image and perception of the world.

I ask my students if they've ever done any charity work. To those who have, I ask how that made them feel. In essence, they tell me that it made them feel good about themselves and about life.

Encourage Teens to be Good?

Should we not be encouraging teens to be good, to be truly loving and selfless, and to not use each other, when we deal with them on issues related to sexuality? Should we not be concentrating our efforts on teaching adolescents the application of unconditional love to the realities of sex, realities to which as we physicians have unique exposure and which we understand? Should we not tell them facts about the inherent risks at which they put each other when they are involved in premarital sex, such as that an asymptomatic partner can give them chlamydia, venereal warts, herpes, hepatitis, etc; that such exposures can lead to cervical cancer, infertility, sick or dead newborns, etc.; that they hurt themselves when they use others, and that it would be more to their advantage if they dealt with problems in positive ways; and that all methods of contraception have significant failure rates?

On this last issue, it is of note that estimated contraceptive efficacy rates were recently revised, taking into account the assessed rate of unreported abortions. The estimated failure rate of oral contraceptives ("the pill") in

the less than 20-year-old age group is 11% (*Family Planning Perspectives* 21:3, 1989). This translates into a 3-year failure rate of 29.5%, nearly thirty pregnancies out of every one hundred girls!

Even smart teens are incredibly uninformed about the risks of premarital sex and, consequently, how unloving an act it is. Love leads one to attempt to reduce risks for others, not to create risks. Family Planning clinics tell us it is okay for teens to have sex as long as both are consenting, but the missing word is *informed* consent. The 19-year-old girl who presents with chlamydia salpingitis has an estimated 30% chance of infertility. If she had been aware of such a risk, would she have thought that a fair price to pay for having sex with a fellow whom she might never see again? Every week in our office we see the surprised looks of people who didn't realize how costly the consequence of their "free" sexual activity could be.

Don't we owe it to teens requesting contraception to spend at least as much time discussing abstinence and the problems associated with premarital sex as whether they have ever had hypertension, migraines, or liver disease (i.e., risk factors for using "the pill")?

Thus, there is a chain of events: low self-esteem leading to premarital sex, leading to an unwanted pregnancy, leading to an unwanted birth or abortion. Optimally, health practitioners would intercede as early as possible to interrupt this chain. We certainly appear to have a responsibility to respond to an adolescent already suffering from low self-esteem by attempting to impact his or her decision to initiate sexual activity. To say, as so many do, that he or she should make this initial decision without our guidance is a cop-out.

As you know, I discontinued dispensing so-called artificial forms of birth control some time ago. Since I am Catholic, I could claim this was solely an effort to follow my Church's teaching. That would be misleading, however, as I have come to believe that the acceptance of such methods has been a predominant force behind the increasingly abusive nature of sexual relationships, both among teens and adults.

Consider Effect

Given some of the notions already discussed, I am asking that we, as practitioners, consider what the effect is on a teen who leaves our office with her first packet of oral contraceptives. Are we doing her and her boyfriend a favor?

There are at least four areas of risk which may be affected by such a prescription:

- the risk of her getting pregnant;
- the risk to her self-esteem;
- the risk of her having an abortion, and
- the risk of her developing a sexually transmitted disease (or s.t.d.).

I have already discussed the first two areas in my comments on some of the main problems today in the field of adolescent sexuality. Discussion of

the last two areas will allow a more complete response to the questions just raised.

To determine the effect on the risk of abortion we must again mainly rely on the two types of studies previously mentioned. School-based clinic studies have shown a marked reduction in fertility (birth) rates, yet have failed to show a corresponding reduction in pregnancy rate. The difference between these two rates is obviously the increase in the abortion rate, i.e., giving teens "the pill" has not been shown to affect their miscarriage rate. On the national level, Zelnik and Kantner confirmed the same trend during periods of greater contraceptive use (they reported a rising proportion of unmarried pregnant teens having abortions, from 23 percent in 1971, to 33 percent in 1976, to 37 percent in 1979); however changes in laws and in societal attitudes make concrete deductions based on their data less appropriate.

Suffice it to say that there exists ample data to support the position that teens using artificial birth control are more likely to have an abortion than teens who don't.

With regard to the fourth risk of dispensing contraceptives to teens, I have seen little direct study of the effect of contraceptive use on the risk of developing an s.t.d. However, we do have evidence of the effect on a teen's level of promiscuity, which is clearly related to the risk of contracting an s.t.d.

As mentioned earlier, there exists a causal relationship between the use of contraceptives and sexual promiscuity. It would seem obvious that if the most dreaded risk of a pleasurable activity is promised to be reduced, then the frequency of that activity will increase. There are at least two studies which confirm this (*Family Planning Perspectives*, 10:6, p. 368, and 13:5, p. 213, table 8). Also, Dr. Robert Kistner of Harvard Medical School, a developer of the oral contraceptive, acknowledged this when he told the American College of Surgeons in 1977, "About ten years ago I declared that the pill would not lead to promiscuity. Well, I was wrong." (*Family Practice News*, December 15, 1977).

Zelnik and Kantner's study shows an increased use of contraceptives among teens during the study period while at the same time showing an increase in promiscuity. This greater promiscuity helps explain the increased pregnancy rate. Exactly how societal attitudes and reliance on the promised efficacy of the pill share responsibility for the increase in promiscuity is unknown.

Birth Control Leads to Promiscuity

There is, in sum, general agreement on the notion that artificial birth control leads to greater promiscuity. Only the magnitude of this effect is unclear.

Sexually transmitted diseases have struck our adolescent population unmercifully. It takes no great sense of logic to understand that increased

promiscuity in response to contraceptive reliance would lead to a greater risk of s.t.d.s and all of the related consequences. Again, it is only the magnitude of this influence which is unknown.

Of course, one can, and nearly everyone does, argue that to avoid this one should simply implore teens to use the big "C". But analysis of this recommendation reveals a few problems. Condoms, for obvious reasons, have never been very popular, let alone among teens. And teens are well known to carry the notion of immortality close to their bosoms, and subsequently to have a great capacity to rationalize their way into risky, "unprotected" situations.

Also, it should be noted that the condom carries a contraceptive failure rate of up to 33% for women less than 25 years old (*New England Journal of Medicine*, 320:12 p. 779). As a contraceptive, condoms need prevent a phenomenon which can only occur during one week out of each month. However, to prevent s.t.d.s, the condom needs to protect against pathogens which are often ever present. Jean Emans, M.D., from Harvard's Adolescent Clinic (who actively promotes condom use among teens), has stated that, "Unfortunately, the record of condom use to date is quite poor among our vulnerable adolescent population." (*The Female Patient*, March, 1989, p. 17).

Lastly, while on the subject of condom prevention of s.t.d.s, we know from a 1988 study that 48% of "mature, well informed" gay men in New York City were still having unprotected anal intercourse with multiple sex partners over five years after the call for condom use inundated their community (*Archives of Sexual Behavior*, 17:6, 1988 — a decidedly pro-gay publication). If AIDS can't scare the highest risk population in the highest risk city in the U.S. into using condoms, how can we assume it will scare teens into doing so?

To sum up this discussion on how use of artificial contraception affects adolescents we must accept that there are many challenging questions. However, as the above discussion indicates, one can, with surprising ease, convincingly argue that dispensing artificial contraception to teens does not significantly lower the risk of pregnancy. It increases the risk of having an abortion and of developing s.t.d.s, and worst of all, and most certainly, it leads to greater problems with self-esteem because teens are encouraged to become involved in sexual relationships of an abusive nature.

Simplistic application of technology to the complex psychosocial problems in this area has met with anything but success. Even if the strategy worked to give adolescents "the pill" to reduce their risk of pregnancy and the condom to reduce their risk of s.t.d.s, what technological marvel could we come up with to protect their self-esteem? How do we protect them from the greatest risk, that of using each other and of being used? What could we use to counter the promotion of selfish approaches to relationships?

Is the medical community neglecting its obligations when contraceptives are dispensed to teens without educating them about these many issues; without giving them the means to make truly informed choices? Clinicians

rather unanimously display remarkable insensitivity to these concerns. Is it not the rule for teens to be given "the pill" without any mention of these deeper, critical issues? It takes time and effort to review such issues with teens during usually brief office visits. However, the prospect of making a positive impact would seem to justify such an investment.

I'm amazed that I can discuss chastity for seven hours with the high risk teens in my classes and have them ask me to come back to tell them more. Teens are desperate to know the truth. Girls especially are concerned since they've seen that their sex has borne the far greater burden of suffering from the sexual revolution through unwanted pregnancies, s.t.d.s, contraceptive side effects, and issues of emotional investment related to sexuality.

I am currently developing a program of sex education for adults. Its purpose is to improve sexual relations among adults and to enable them to provide proper counsel to young people. I expect it will run six hours and is far beyond the scope of this letter or of the usually hurried exchanges in the office. This letter is meant only to touch on a few issues pertinent to clinical practice.

There is much to discuss in these areas. Even after having been interested and involved in sex education for some time, I have much more to learn. I would be very interested in any thoughts you might have. You are all bright, compassionate physicians, and without question, I can gain from your insights. I'm likely to be much more involved in this field in the near future and any help I can receive from you would be greatly appreciated.
