RISK AND PROTECTIVE FACTORS RESOURCE

The following excerpted pages are from the publication, **Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases**. This chapter summarizes risk and protective factors that affect teens' sexual behavior that have been shown to be the most amenable to direct change on teen behavior through pregnancy and STI prevention programs.

Pregnancy prevention programs should target risk and protective factors that:

- Have a significant causal impact on one or more types of sexual behavior affecting the incidence of teen pregnancy or STI.
- Can be changed markedly by parents or other people or organizations concerned with teen pregnancy and sexual health.

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- ☆ More than 500 factors are known to increase or decrease the chances that teens will engage in risky sexual behavior.
- ☆ Both risk and protective factors influence teen sexual behavior.
- ☆ Some factors involve sexuality directly; others affect sexuality indirectly.
- ☆ Risk and protective factors are rooted in:
  - communities (e.g., exposure to violence and substance use),
  - families (e.g., the presence of both biological parents, parents who express and model responsible values about sex and contraception, a close relationship with parents),
  - friends and peers (e.g., poor performance in school, drug use, permissive and unprotected sex),
  - romantic partners (e.g., an older boyfriend),
  - teens themselves (e.g., values, attitudes, perceptions of peer norms, self-efficacy, and intentions about sex or the use of contraception).
- ☆ Of the more than 500 known factors, teens' own sexual beliefs, values, and attitudes are the most strongly related to sexual behavior.
- ☆ Some factors can be more easily modified through programmatic interventions than others.
- ☆ Organizations concerned with preventing teen pregnancy and STD should focus on factors that are most strongly related to sexual behavior and can be changed markedly by the organizations' programs.

CHAPTER THREE

Factors That Affect Teens' Sexual Behavior

Parents and other concerned adults cannot control teens' sexual behavior directly, but they can attempt to affect the factors that influence teens' sexual decisions and behavior. Logic and experience suggest that the more people know about those factors and the more effectively people address them, the more success they'll have in reducing sexually risky behavior.

Understanding the factors that influence teen sexual behavior is necessary not only for changing behavior, but also for identifying teens who are most at risk of having sex and having unprotected sex. First people can use these factors to identify those teens at greater risk; then they can address the important factors affecting teen behavior. This chapter summarizes many of the important factors and explains their implications for people working to help young people avoid sexual risk-taking.

Factors that influence teens' sexual decisions and behavior include both risk factors and protective factors. *Risk factors* encourage behavior that could result in a pregnancy or STD or discourage behavior that could prevent those outcomes. *Protective factors* discourage behavior that could lead to a pregnancy or STD or encourage behavior that can prevent them. Risk and protective factors may be equally important. If the risk factors in a teen's life diminish or the protective factors increase, or both, the teen will be much less likely to have sex, fail to use condoms or other forms of contraception, become pregnant or cause a pregnancy, or contract an STD.

This chapter uses the words "encourage behavior" and "discourage behavior" to describe the effects of risk and protective factors because the terms imply causality. Causality is important because the goal of most programs is to change behavior. If a factor is only correlated with a behavior, and does not actually affect that behavior, then changing the factor will not change the behavior.

Research cannot always demonstrate causality, and readers should always question whether a risk or protective factor actually influences a sexual behavior or is just related to it. Unless specifically noted, all of the factors discussed in this chapter have shown some evidence that they have a causal impact on behavior.

Since parents and other adults cannot change teen behavior directly, the question becomes: Which risk and protective factors should they target? The answer is twofold:

- ☆ Factors that have a significant causal impact on one or more types of sexual behavior affecting the incidence of teen pregnancy or STD, and
- ☆ Factors that can be changed markedly by parents or other people or organizations concerned with teen pregnancy and sexual health.

Logically, if a risk or protective factor satisfies only one of these two criteria, it is not worth targeting, because it will not reduce pregnancy or STD rates. In other words, an unchangeable factor that affects sexual behavior is no more

worth pursuing than a changeable factor that does not affect sexual behavior significantly.

This conclusion raises two very important questions, both of which this chapter attempts to answer:

- ☆ Which factors have the greatest causal impact on adolescent sexual behavior?
- ☆ Which factors are most amenable to change by pregnancy and STD/HIV prevention programs?

METHODOLOGY

This chapter summarizes the results of about 450 studies of risk and protective factors [1]. To be included, the studies had to meet the following criteria:

- ☆ Be conducted in the United States.
- ☆ Examine the impact of factors on initiation of sex, frequency of sex, number of partners, condom or other contraceptive use, pregnancy, childbearing, or STD.
- ☆ Be based on a sample of teenagers roughly 18 or younger.
- ☆ Have a sample size of at least 100 teens for significant results and at least 200 teens for nonsignificant results.
- ☆ Meet scientific criteria required for publication in professional peer-reviewed research journals or other publications.
- ☆ Be published between 1990 and 2007, inclusive.
- ☆ Include multivariate analyses.

WHAT FACTORS AFFECT TEEN SEXUAL BEHAVIOR MOST?

The studies revealed that more than 500 factors affect one or more of the eight important measures of teen sexual behavior and its outcomes: age at which sex is initiated, frequency of sex, number of partners, use of condoms, use of other methods of contraception, pregnancy, childbearing, and STD.

Nearly all young people experience pressures of some kind to have sexual intercourse and are therefore at risk of pregnancy and STD. It is simply not the case that only one group of teens, only one ethnic group, only low-income teens, only teens in a particular neighborhood, or only students in "other" schools engage in sex and become pregnant or contract an STD. Sexual activity, pregnancy, and STD cut across all of these groups.

Risk and protective factors increase or decrease the chances that a teen will engage in risky sexual behavior. As noted above, the presence of more risk factors and fewer protective factors in a teen's life increases the chances that that teen will have unprotected sex and become pregnant (or cause a pregnancy) or contract an STD.

Because so many factors affect teen sexual behavior, focusing on only one of them is unlikely to have much impact unless that factor is an extremely important one (e.g., intention to have sex). Targeting several important factors is a more promising approach. To that end, this chapter focuses on the most important factors and the dominant themes among them. Table 3-1 includes factors that show the strongest and most consistent evidence of significantly affecting teens' sexual behavior.[1]

1. To be included in Table 3-1, four conditions had to be met: 1) the pattern of results across studies indicating that a particular factor significantly affects behavior could not have occurred by chance; 2) at least two-thirds of the studies had to show that a particular risk or protective factor exerted a consistent, significant effect on behavior, rather than being not significant or having significant results in the opposite direction (this "2 to 1" rule excludes many factors, but increases the chances that a factor will be important in every community); 3) at least three multivariate studies had consistently to support the conclusion that a particular factor was a risk (or protective) factor for a particular behavior; and 4) at least one of the studies had to have a large sample size.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
Environmental Factors		
Community		
PERCENTAGE FOREIGN-BORN		
+ High proportion of foreign-born residents	*	In general, pregnancy and STD prevention programs cannot affect the percentage of foreign-born residents in a community.
COMMUNITY DISORGANIZATION		
- Greater community social disorganization (e.g., violence, hunger, substance use)		In general, pregnancy and STD prevention programs do not have the resources or capability of markedly changing community-wide social disorganization. In some communities, these and other programs can collaborate to address larger social issues.
Family		
FAMILY STRUCTURE		
+ Live with two parents (vs. one parent or step-parents)	*	In general, pregnancy and STD prevention programs cannot affect marital status, divorce risk, or living arrangements of families. If their agencies offer marriage or family counseling, they may be able to help parents stay together.
- Family disruption (divorce, change to single-parent household)	*	
EDUCATIONAL LEVEL		
+ High level of parental education	*	In general, pregnancy and STD prevention programs cannot affect parents' educational level. In some communities, programs with a holistic approach may be able to provide guidance and counseling to parents and encourage and facilitate their obtaining a higher education.
SUBSTANCE ABUSE		
- Household substance abuse (alcohol or drugs)	**	In general, pregnancy and STD prevention programs can have little effect on whether parents or siblings of teens abuse alcohol or drugs. Some programs may be able to provide alcohol and drug abuse prevention programs and thereby reduce parental abuse.

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* = Extremely difficult for most pregnancy and STD prevention programs to change directly themselves, although they can work with other agencies to change policies.

** = Difficult for most pregnancy and STD prevention programs to change unless they have special programs or capabilities.

*** = Most amenable to change directly by pregnancy and STD prevention programs. These factors are italicized.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
POSITIVE FAMILY DYNAMICS AND ATTACHMENT		
+ High-quality family interactions, connectedness, satisfaction with relationships	**	In general, pregnancy and STD prevention programs can have little effect on family interactions and connectedness. Some agencies may be able to provide intensive family guidance and counseling and thus affect family interactions.
+ Greater parental supervision and monitoring	**	In general, pregnancy and STD prevention programs can have little effect on parental supervision and monitoring. Some more holistic programs may be able to implement programs for parents that encourage them to supervise and monitor their teen children appropriately.
- Physical abuse and general maltreatment	**	In general, pregnancy and STD prevention programs can have little effect on physical abuse and maltreatment within the family. Some agencies may be able to provide intensive family guidance and counseling and thus affect abusive behavior.
FAMILY ATTITUDES ABOUT AND MODELING OF SEXUAL RISK-TAKING AND EARLY CHILDBEARING		
- Mother's early age at first sex and first birth	*	Programs cannot affect a teen's mother's prior behavior. Programs can prevent teens from becoming mothers and thereby help the next generation.
- Older sibling's early sexual behavior and early age at first birth	**	In general, pregnancy and STD prevention programs cannot affect the previous behavior of older siblings. They can affect the behavior of teens, who may have younger siblings.
+ Parental disapproval of premarital sex or teen sex	**	Pregnancy and STD prevention programs can provide parents with accurate information about teen sexual behavior and its consequences. Some programs, especially faith-based ones, may emphasize conservative religious values about premarital sex and teen sex. Many programs may encourage parents to talk to their teens about abstaining from having sex.
+ Parental acceptance and support of contraceptive use for sexually active teens	**	Pregnancy and STD prevention programs can provide parents with accurate information about teen sexual behavior, its consequences, and the effectiveness of condoms and contraception. Some programs may be willing to talk to parents about encouraging their teens to use contraception if they do have sex.
COMMUNICATION ABOUT SEX AND CONTRACEPTION		
+ Greater parent-child communication about sex and condoms or contraception, especially before teen initiates sex	***	Pregnancy and STD prevention programs can increase parent-child communication about sex, condoms, and other contraception through school homework assignments, special programs for parents, college courses for parents, and other approaches.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
Peer		
AGE		
- Older age of peer group and close friends	**	In general, pregnancy and STD prevention programs cannot easily affect the age of teens' peers. Some programs may be able to provide activities that encourage teens to interact with people their own age or encourage same-age friends in other ways.
PEER ATTITUDES AND BEHAVIOR		
- Peers' alcohol use, drug use, deviant behavior	**	If friends can be reached, some pregnancy and STD prevention programs with a youth development emphasis may be able to reduce alcohol and drug abuse and other non-normative behavior.
- Peers' pro-childbearing attitudes or behavior	***	If peers can be reached, sex education programs can reduce pro-childbearing attitudes and behavior. If peers cannot be reached, programs can implement activities in small or large group settings that demonstrate peer support for avoiding pregnancy.
- Permissive values about sex	***	If friends can be reached, agencies can implement effective abstinence or sex and STD/HIV education programs that change permissive values and delay the initiation of sex. If peers cannot be reached, programs can implement activities in small or large group settings that demonstrate peer support for delaying sex.
- Sexually active peers	***	If friends can be reached, abstinence or sex and STD/HIV education programs can change permissive values about sex and delay the initiation of sex. If friends cannot be reached, programs can implement activities demonstrating that perceptions of peer sexual activity are typically exaggerated.
+ Positive peer norms or support for condom or contraceptive use	***	If friends can be reached, sex and STD/HIV education programs or clinic protocols can increase both support for condom and contraceptive use and actual use of condoms and contraceptives. If peers cannot be reached, programs can implement activities in small or large group settings that demonstrate peer support for condom and contraceptive use for sexually active teens.
+ Peer use of condoms	***	If peers can be reached, sex and STD/HIV education programs can increase condom use. If peers cannot be reached, programs can implement activities in small or large group settings that demonstrate peer support for condom use.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
Romantic Partner		
PARTNER CHARACTERISTICS		
- Having a romantic partner who is older	**	Pregnancy and STD prevention programs can encourage teens to date people their own age. Such efforts have not yet been evaluated.
+ Partner support for condom and contraceptive use	**	If partners can be reached, sex and STD/HIV education programs can improve attitudes toward condom and contraceptive use. If partners cannot be reached, programs can implement activities in small or large group settings that demonstrate peer support for condom use.
Individual Factors		
BIOLOGICAL FACTORS		
+/- Being male	*	Within reason, it is not possible to change these factors.
+/- Being older	*	
+/- Being physically more mature	*	
RACE/ETHNICITY		
- Being African-American (vs. white)	*	Pregnancy and STD prevention programs cannot affect race or ethnicity, but sometimes, in collaboration with other programs, they can help reduce minority poverty or minority cultural values that may contribute to sexual risk.
- Being Hispanic (vs. non-Hispanic white)	*	
ATTACHMENT TO AND SUCCESS IN SCHOOL		
+ Greater connectedness to school	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to implement tutoring, mentoring, job shadowing, arts, sports, service learning, or other initiatives to help keep teens in school, keep them involved, improve their grades, and improve their aspirations.
+ Higher academic performance	**	
- Being behind in school or having problems in school	**	
+ High educational aspirations and plans for the future	**	
ATTACHMENT TO COMMUNITY		
+ Being involved in the community	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to implement arts, sports, service learning, or other community programs to help teens be involved in their communities.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
ATTACHMENT TO FAITH COMMUNITIES		
+ Having a religious affiliation	**	Most pregnancy and STD prevention programs cannot strive to increase involvement in religious organizations. However, faith communities can implement youth programs or initiatives that may increase young people's involvement and improve their understanding of their religion's values about sexuality.
PROBLEM OR RISK-TAKING BEHAVIOR		
- Alcohol use	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to offer initiatives that reduce alcohol or drug use.
- Drug use	**	
- Being part of a gang	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to implement initiatives that reduce gang membership.
- Physical fighting and carrying weapons	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to implement initiatives that reduce fighting, violence, and other problem behavior.
- Other problem behavior or delinquency	**	
OTHER BEHAVIOR		
- Working for pay more than 20 hours per week	**	Most pregnancy and STD prevention programs will not wish to discourage teens from working and having the greater autonomy that accompanies work. However, some may be willing to discourage teens from working more than 20 hours per week.
+ Involvement in sports (girls only)	**	Some pregnancy and STD prevention programs with a youth development emphasis may be able to implement sports programs for girls.
COGNITIVE AND PERSONALITY TRAITS		
+ Higher level of cognitive development	**	Most pregnancy and STD prevention programs are not designed to increase cognitive development. Some with a youth development emphasis may be able to implement initiatives that increase cognitive development slightly.
+ Greater internal locus of control	**	A teen's locus of control is difficult to change. Some programs with an intensive youth development focus may be able to improve teens' internal locus of control.
EMOTIONAL WELL-BEING AND DISTRESS		
- Depression and thoughts of suicide	**	Most pregnancy and STD prevention programs are not equipped to address depression or thoughts of suicide. Some programs may be able to refer teens to agencies that provide needed help or may provide such services themselves.

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions to Change Factors
SEXUAL BELIEFS, ATTITUDES, AND SKILLS		
- More permissive attitudes toward premarital sex	***	Pregnancy and STD prevention programs can implement abstinence education, sex and STD/HIV education, and clinic protocols that target these factors. Such initiatives have been demonstrated to delay the initiation of sex, reduce the frequency of sex and the number of partners, and increase condom or contraceptive use.
+ Taking a virginity pledge	***	
+ Greater perceived male responsibility for pregnancy prevention	***	
+ Stronger beliefs that condoms do not reduce sexual pleasure	***	
+ Greater value of partner appreciation of condom use	***	
+ More positive attitudes toward condoms and other forms of contraception	***	
+ More perceived benefits and/or fewer costs and barriers to using condoms	***	
+ Greater confidence in ability to demand condom use	***	
+ Greater confidence in using condoms or other forms of contraception	***	
+ Greater motivation to use condoms or other forms of contraception	***	
+ Greater intention to use condoms	***	
+ Greater perceived negative consequences of pregnancy	***	
+ Greater motivation to avoid pregnancy and STD	***	

Table 3.1: Important Risk and Protective Factors and the Feasibility of Changing Them (Con't.)

Risk (-) and Protective (+) Factors	Feasibility of Changing[1]	Possible Interventions To Change Factors
RELATIONSHIPS WITH ROMANTIC PARTNERS AND PREVIOUS SEXUAL BEHAVIOR		
- Dating more frequently	**	Pregnancy and STD prevention programs can encourage parents to appropriately monitor and supervise teen dating and going steady. Programs can also encourage young people to delay dating and going steady and to participate in group activities rather than one-on-one dates. Such efforts have not been evaluated.
- Going steady, having a close relationship	**	
- Ever kissed or necked	**	
+ Older age at first voluntary sex	***	Pregnancy and STD prevention programs can implement abstinence education and sex and STD/HIV education that have been demonstrated to delay the initiation of sex.
- Greater frequency of sex	***	Some sex and STD/HIV education programs and clinic protocols can reduce the frequency of sex and the number of sexual partners (and hence the number of new sexual relationships). Others can encourage young people in new sexual relationships to begin using contraception earlier in their relationship.
- Having a new sexual relationship	***	
- Greater number of sexual partners	***	
+ Discussing sexual risks with partner	***	Pregnancy and STD prevention programs can implement sex and STD/HIV education and clinic protocols that increase communication about sexual risks and prevention of pregnancy and STDs.
+ Discussing pregnancy and STD prevention with partner	***	
+ Previous effective use of condoms or contraception	***	Pregnancy and STD prevention programs can implement sex and STD/HIV education programs and clinic protocols that increase condom and contraceptive use, thereby reducing the risk of pregnancy and STDs.
- Previous pregnancy or impregnation	***	
- History of prior sexual coercion or abuse	*	Pregnancy and STD prevention programs typically are not equipped to address the consequences of past sexual abuse or to prevent subsequent abuse. They can refer sexually abused young people to intensive, specialized counseling services, if they exist, and some programs may be equipped to implement support groups for victims.
- Same-sex attraction or sexual behavior	**	Pregnancy and STD prevention programs cannot affect sexual orientation, but some programs designed for gay, lesbian, and questioning youth may be able to reduce their sexual risk-taking.
- Being married	**	Most programs do not include delaying marriage in their mission. Some programs, especially those with counseling components, may encourage young people to think seriously about the implications of early marriage.

The factors identified in Table 3-1 support a wide variety of theories about risky adolescent sexual behavior—theories involving social disorganization in the community, theories involving parenting practices and parent values about adolescent sexuality, biological theories, theories suggesting that sexual risk-taking is part of a larger syndrome of risk-taking or deviant behavior, and social psychological theories of rational behavior. No single theoretical perspective is sufficient to explain teens' sexual behavior: the overall picture is much more complex.

Environmental Factors

Four groups of factors found to be most influential on teens' sexual behavior are environmental. Those factors characterize the community in which a teen lives, his or her family, peers and best friends, and the teen's romantic partners.

Community

The community a teen lives in influences his or her sexual behavior. In particular, teens who live in disorganized communities—those with higher rates of substance abuse, violence, and hunger—are more likely to begin having sex early and to have a child. Teens who live in communities with a higher proportion of foreign-born residents are more likely to delay having sex. According to at least one study, this finding may reflect the less permissive sexual values of foreign-born parents.

Family

Family characteristics are very important in determining risk. Teens who live with both parents and enjoy close relationships with them are less likely to have unprotected sex and become pregnant. Specifically, if teens live with both biological parents (instead of only one parent or step-parents), they are less likely to have sex, but if they do, they are likely to have sex less frequently. A majority of studies find that teens living with both parents are less likely to become pregnant (or cause a pregnancy) or to give birth (or father a child). If biological parents divorce or separate, their children are more likely to initiate sex at an early age than if the parents do not divorce or separate.

Teens whose parents are more educated are less likely to become pregnant than teens whose parents have less education. Family income is also a factor: the majority of studies found that teens in families with higher incomes were less likely to become pregnant or to bear children. These findings regarding parents' education and income may reflect the emphasis that many such parents place on obtaining an education, pursuing a career, and avoiding early childbearing, as well as, to some extent, the greater resources available to support teens in these pursuits.

If teens experience considerable parental support and feel connected to their parents, they are less likely to initiate sex at an early age, and they have sex less frequently. If parents monitor and supervise their teens appropriately, the teens are likely to have fewer sexual partners than if parents do not monitor them (or, according to at least one study, if parents monitor them excessively). At the extreme, if teens have been maltreated and physically abused by their families, then they are much more likely to have sex at an early age and to become pregnant.

Family abuse of alcohol or drugs increases the chances that teens will have sex more frequently and with more partners. There are two possible reasons for this effect: family substance abuse may encourage young people to drink and use drugs themselves, which can lead to more frequent sex with more partners, or family substance abuse may simply be a marker for more general family dysfunction, which can lead to sexual risk-taking by teens.

If family members, especially parents, express values or model behavior consistent with sexual risk-taking or early childbearing, teens are more likely to have unprotected sex and become pregnant (or cause their partners to become pregnant). Parents may do this in a variety of ways, including conveying permissive attitudes about premarital sex or teen sex, voicing negative attitudes about contraception, or having been

teen parents themselves. Similarly, teens whose older siblings model early sex or childbearing are more likely to have early sex themselves. In contrast, parental disapproval of teen sex reduces the chances that teens will have sex, and parental support of contraceptive use increases the chances that teens will use contraception if they do have sex.

When parents have conversations with their children about sex and contraception well before the children become sexually active, the initiation of sex may be delayed and the use of condoms or other contraceptives increased. This effect is most likely to occur when the teen is a daughter, when the parent is the mother, when the teens and their parents feel connected to one another, when the parents disapprove of teens having sex or support contraceptive use, and when parents can discuss sexuality in an open and comfortable manner.

Peers and best friends

Sexual behavior is one of the many areas in which teens are influenced by their best friends and peers. Teens are more likely to have sex if their best friends and peers are older, use alcohol or drugs, or engage in other negative behavior. Similarly, they are more likely to have sex if they believe their friends have more positive attitudes toward childbearing, have permissive values about sex, or are actually having sex. If teens believe their friends support condom use or actually use condoms, chances are greater that they will use condoms themselves.

Romantic partners

While simply having a romantic partner increases the chances of sexual activity, having an older romantic partner increases them even further. Having an older partner also lowers the chances that contraception will be used and increases the chances of pregnancy and contracting an STD. If teens' partners support condom or contraceptive use, then teens are more likely to use them if they have sex.

Individual Factors

Fifteen groups of factors found to be particularly influential on teens' sexual behavior are classed as individual. They include biological factors, race and ethnicity, connection to family, connection to school and to doing well in school, connection to religion, connection to other organizations or adults in the community, involvement in gangs, alcohol and drug use, aggressiveness, involvement in problem or sensation-seeking behavior, paid work, involvement in sports, cognitive and personality traits, sexual beliefs, attitudes, skills, motivations, and intentions, and relationships with romantic partners and previous sexual behavior.

Biological factors

Studies have found that age, physical development, and gender have a dramatic effect on teens' sexual behavior. As they become older, teens are much more likely to have sex. Moreover, if they mature physically at an early age, begin menarche early, and appear older than their age, they are also more likely to initiate sex early.

Some effects of getting older are strictly physical, including increased sexual maturity and higher testosterone levels, which may lead to a greater desire for intimacy and sex, greater sexual attractiveness, or both. Other effects are social, such as increased pressure from peers to have sex, changes in perceived norms about sexual and contraceptive behavior, and increased opportunities to have sex, which come with greater freedom and independence.

In addition, teens are likely to have sex more frequently and with more partners as they get older. When teens first have sex, they most often use condoms, in part because they have sex sporadically; older teens are more likely to use long-lasting methods of contraception, such as oral contraceptives or Depo Provera. At the same time, teens are increasingly likely to become pregnant (or to impregnate someone) and to parent a child as they grow older. In other words, because more teens have sex more often as they grow older,

they are increasingly likely to become pregnant, even though they may also be more likely to use contraception.

A teen's gender is another very important biological factor. Overall, boys claim that they have more sexual partners and use condoms more often, although these findings may reflect response biases. Girls are more likely to contract an STD.

Age and gender interact with other factors. For instance, having an older romantic partner increases the likelihood of sexual intercourse for all teens; however, the likelihood is greater for younger teens, especially those in middle school, than for older teens. This factor is also more important for girls than for boys.

Some of these biological factors simply cannot be changed. However, organizations can use them to identify young people who may be more susceptible to sexual risk-taking. Furthermore, organizations can change some attitudes associated with biological factors, such as perceptions of gender roles or expectations of sexual activity for different age groups.

Race and ethnicity

Compared to non-Hispanic white teens, African–American teens are more likely to have sex at an earlier age, to have more sexual partners, to become pregnant, to give birth, and to contract an STD. Findings are mixed regarding condom use, with a few studies indicating that African-American teens are more likely to use condoms than non-Hispanic white teens.

Hispanic teens are more likely to become pregnant than non-Hispanic white teens. Most studies indicate they are not more likely to have sex at an early age, but some studies indicate they are less likely to use contraception.

Some of the effects of race and ethnicity diminish when studies take into account family or community education, employment, and income. That is, it is not simply minority status per se that affects teen sexual behavior, pregnancy, and STD risk, but rather the poverty and lack of opportunity often associated with being in a minority group that affects those outcomes. Yet studies have found that controlling for socioeconomic status does not erase the effects of minority status on teen sexual behavior or pregnancy. This finding suggests that cultural values—such as greater emphasis on the family, greater acceptance of early childbearing, or expectations of submissiveness to men—may also contribute to the effects of race and ethnicity. Still other factors, such as experiencing discrimination or racism, may also play a role.

Connection to family

Connection to family is both an individual characteristic and a family characteristic. It is discussed above under family characteristics.

Connection to school and success in school

When teens stay in school, feel connected to their schools, earn good grades, do not fall behind in school, have plans for higher education beyond high school, avoid problems in school, or do all of these, they initiate sex later and are less likely to have children.

Several studies have found that involvement in school organizations is related to less sexual risk-taking. A methodologically strong study found that simply belonging to school organizations had no impact on teen childbearing; however, the study did find that substantial involvement in school organizations, particularly in school-based religious organizations among non-Hispanic white teens and in school clubs among African–American teens, was related to lower rates of teen childbearing.

Connection to religion

Teens who have a strong religious affiliation are less likely to initiate sex, and some studies indicate that teens who attend religious services frequently are less likely to have sex. The direction of causality is not entirely clear, however. Just as attachment to faith communities may affect

sexual behavior, sexual behavior may also affect attachment to faith communities. For example, teens who have had sex may feel less comfortable in places of worship and may be less likely to attend services.

Connection to other community organizations or adults

When teens are more involved in their communities and have mentors, they are less likely to engage in sexual behavior.

Involvement in gangs

Several studies suggest that teens who belong to gangs are more likely to have sex, to have more sexual partners, and to become pregnant. It is not clear whether gang membership per se produces this elevated risk or simply the fact that teens in gangs have other risk factors as well.

Alcohol and drug use

Numerous studies have found relationships between teens' use of alcohol and illegal drugs and an increased likelihood of having sex, having sex more often, having sex with more partners, and pregnancy.

It is plausible that drinking alcohol and using drugs may lower inhibitions, diminish the ability to assess risks, or increase sexual aggression, thus accounting for the measured relationship between alcohol and drugs and teen sexual activity. However, it is also possible that part or all of the effect is caused by other factors, such as poor performance in school, general risk-taking or sensation-seeking, lack of parental monitoring, and so on.

One study that controlled for some of these factors found that use of alcohol and other drugs was not related to sexual activity for either gender, nor was it related to use of female methods of contraception. However, drinking alcohol was negatively related to boys' use of condoms. Another study found that, while both alcohol and drug use in the past were negatively related to condom use, drug and alcohol use during the most recent sex was not negatively related to use of condoms. This finding suggests that something other than lowered inhibitions at the time of sex may explain the relationship. Still other studies have found either no relationship between substance use and sexual risk-taking or no significant relationship once other factors were controlled. Although alcohol and other drug use are included in Table 3-1, their causality is questionable.

Aggression

Physical fighting and carrying weapons are also related to having sex, more sexual partners, and pregnancy, but the relationship may not be causal.

Involvement in problem or sensation-seeking behavior

Engaging in problem or sensation-seeking behavior is related to poorer use of contraception, pregnancy, and childbearing. Problem or sensation-seeking behavior may expose teens to norms that favor sexual risk-taking or to more opportunity or desire to have unprotected sex. Alternatively, the relationship between problem behavior and sexual risk-taking may simply reflect family or community characteristics such as poverty, single-parent homes, lack of supervision, or a general propensity to take risks. Again, causality is not clear.

Paid work

Several studies have indicated that teens with paying jobs, especially those who work more than 20 hours per week, are more likely to have sex, to have sex more often, and to have more sexual partners. Paid work may increase teens' sense of independence, their mobility, and their opportunities to have sex.

Involvement in sports

A few studies have found that, for teen girls but not teen boys, participation in sports is related to delayed initiation of sex, less frequent sex, greater

use of contraception, and lower pregnancy rates. These studies suggest that girls' participation in sports motivates them to avoid pregnancy, which, in turn, delays initiation of sex. However, the relationship between participation in sports and lower rates of pregnancy is less clear. Perhaps it is because girls who are athletes are more likely than non-athletes to be young, better educated, and non-Hispanic white, characteristics that reduce their risk of becoming pregnant.

Cognitive and personality traits

Teens with higher cognitive development are less likely to have sex and more likely to use contraception if they do have sex. Teens with a greater internal locus of control—that is, who believe that they rather than external events control their lives—have sex less frequently, use condoms more frequently, and are less likely to become pregnant. Both of these factors may be causal.

Although high self-esteem and positive self-concept are commonly believed to be protective factors for sexual risk-taking, the picture is actually quite mixed. A few studies, including some with large samples that are representative of teens across the United States, have found that self-esteem and positive self-concept are protective factors against initiation of sex, use of contraception, and pregnancy. However, the large majority of studies has found that self-esteem and self-concept are not significantly related to sexual behavior. A few studies have found self-esteem to be protective only for girls or only for middle school (as opposed to high school) students. At least one study actually found that having sex can increase self-esteem. Thus, the relationships between these factors and sexual behavior are unclear and probably quite complex.

Teens who suffer from depression, thoughts of suicide, or fear of untimely death are more likely to have sex. Such emotional distress may affect their motivation to avoid pregnancy or STDs, diminish their ability to assess risk, or lead them to want to escape through sexual involvement. Alternatively, emotional distress may result from a negative environment, and that environment may actually cause the sexual risk-taking.

Sexual beliefs, attitudes, skills, motivations, and intentions

The strongest risk and protective factors are teens' own sexual beliefs, values, attitudes, skills, and intentions. Teens are more likely to have sex, to have sex more frequently and to have more partners, if they have permissive attitudes toward premarital sex. They are less likely to have sex if they have taken a virginity pledge.

Sexually active teens are more likely to use condoms or other forms of contraception if they believe that teen boys share responsibility for pregnancy prevention, that condoms do not reduce sexual pleasure, and that their partner will appreciate their using a condom. They are also more likely to use condoms or other forms of contraception if they have positive attitudes toward condoms and other forms of contraception, perceive more benefits and fewer costs and barriers to using condoms, have greater confidence in their ability to demand and use condoms or other forms of contraception, have greater motivation to use condoms or other forms of contraception to avoid pregnancy and STD/HIV, intend to use condoms, and actually carry condoms.

All of these beliefs, attitudes, skills, motivations, and intentions can be considered "sexual" factors and also "proximal" factors because they are closely linked conceptually and logically to a related sexual behavior and they influence that behavior directly. For example, values regarding sex are more closely related conceptually to actually having sex than is the proportion of the community that is foreign-born. The latter is considered "distal" and "nonsexual" because it influences sexual behavior indirectly.

While both common sense and research indicate that these proximal sexual factors have an impact on sexual behavior, it is also true that sexual behavior may very well affect these factors. For example, having sex and using condoms may affect attitudes about having sex, perceptions

of peer norms about sex, and perceived ability to use condoms. Thus, causality may operate in both directions.

Sexual risk and protective factors are particularly important for several reasons. First, they are well supported by a variety of social psychological theories, for example, social cognitive theory [2], theory of planned behavior [3], the information-motivation-behavioral skills model [4], and the health belief model [5]. Second, they are more closely related conceptually to a particular sexual and contraceptive behavior than are other factors. Third, they are more strongly related statistically to some types of sexual and contraceptive behavior than are most of the other factors. Finally, some of these factors form the theoretical basis for many sex and STD/HIV education programs that have reduced sexual risk-taking [6].

Relationships with romantic partners and previous sexual behavior

Not surprisingly, when teens begin dating frequently, go steady, and kiss and neck, they are more likely to have sex. These early romantic relationships may increase the desire, opportunity, and pressure to have sex. Furthermore, sex within a romantic relationship may be more consistent with teens' values and perceived norms than sex in casual relationships.

When the romantic partner of a teen is three or more years older, the teen is especially likely to have sex. The impact of this age gap is quite large, especially among middle school girls.

Teens who begin having sex at an earlier age are less likely to use contraception and more likely to become pregnant and/or to become a parent. They are also likely to accumulate a greater number of lifetime sexual partners and are less likely to use condoms. These behavioral factors contribute to a higher rate of STD. In addition, young girls are not fully physically mature and are more susceptible to STD.

The relationship between number of sexual partners and STD is especially well established. Many studies have demonstrated that having a large number of sexual partners greatly increases the chances of contracting an STD.

Several studies have shown that teens often use condoms initially in sexual relationships, but as their relationships continue and they have sex more frequently, they use long-term hormonal contraceptives such as oral contraceptives or Depo Provera instead.

Teens who discuss HIV and other STDs, methods of preventing infection, and their past sexual histories or risk are more likely to use condoms. Similarly, teens who discuss methods of preventing pregnancy are more likely to use contraception.

Not surprisingly, teens who previously used condoms or other contraceptives are more likely to use them on subsequent occasions. However, this finding may reflect other factors and may not be causal in itself.

Being married reduces the number of sexual partners and increases the chances of pregnancy. Because pregnancy can also lead to marriage, the direction of causality is not entirely clear.

Having been pregnant (or having gotten someone pregnant) increases both the risk that a young person will not use condoms during sex and, according to a few studies, the risk of another pregnancy. Causality regarding these factors is unclear, however, because a history of pregnancy undoubtedly entails some of the risk and protective factors discussed above, and these factors continue to increase the risk of pregnancy.

Prior sexual abuse is highly related to early initiation of sex, greater number of sexual partners, poor condom use, poor contraceptive use, pregnancy, and STD. However, there is some question about whether sexual abuse causes teens to then engage voluntarily in risky sexual behavior. Young people who have been sexually abused have undoubtedly also been exposed to a variety of other risk factors. In addition, the sexual abuse may distort their understanding of appropriate sexual and contraceptive behavior and may diminish

their ability to reject sex or to use contraception. Thus, it is not entirely clear whether it is exposure to other risk factors or sexual abuse itself that leads to greater voluntary sexual risk.

Sexual activity with persons of the same sex is another risk factor. Young people who engage in same-sex activity are more likely to have heterosexual sex and to have more sexual partners.

Generalizability Across Different Subgroups of Teens

When developing programs for teens, communities and organizations are faced with the question of whether the risk and protective factors in Table 3-1 will apply to the group they are targeting. The best way of assessing the impact of these factors on any particular group of teens is to design and conduct research specifically for those teens. Typically, however, organizations do not have sufficient time or resources to undertake such research.

Fortunately, the factors presented in Table 3-1 are widely applicable. Virtually all of them were found to be statistically significant in at least two-thirds of the studies that measured their impact. (Statistical significance is a measure of how confident one can be in the results of a study.) The studies often sampled varied groups of young people, thereby increasing the chances that the factors will be significant in a range of communities. In addition, the studies demonstrated that most of the factors do have an impact on various subgroups of teens, especially teens in the three largest ethnic groups, and they often have an effect on teens of both sexes.

On the other hand, this is not always the case. For example, the following factors appear to be effective only for certain subgroups. Participating in sports appears to be a protective factor only for girls, having an older romantic partner is a stronger risk factor for girls than for boys, and communicating with parents about sex is a greater protective factor for girls than for boys. This short list does not imply that all other factors affect different racial/ethnic groups or genders equally. It simply means that multiple studies show that these three factors consistently have differential effects.

Dominant Themes

The risk and protective factors that exert the strongest influence on teen sexual behavior operate in four general areas, some of which can be targeted by organizations that want to reduce teen pregnancy and the spread of STD/HIV:

- ☆ Individual biological factors (e.g., age, physical maturity, and gender)
- ☆ Disadvantage, disorganization, and dysfunction in the lives of the teens themselves and their environments (e.g., rates of substance abuse, violence, and divorce; also level of education).
- ☆ Sexual values, attitudes, norms, and modeled behavior (e.g., teens' own values about sexual behavior as well as those expressed by parents, peers, and romantic partners).
- ☆ Connection to adults and organizations that discourage sex, unprotected sex, or early childbearing (e.g., attachment to parents and other adults in their schools and places of worship).

WHICH FACTORS CAN BE CHANGED?

The answer to this question depends to some degree on the organizations involved. Organizations concerned with preventing teen pregnancy, STD/HIV, or both encompass a wide range of activities, from STD/HIV education to family planning to youth development to parental education. Table 3-1 lists the risk and protective factors that show the strongest evidence of an impact on teen sexual behavior and specifies which factors can be most easily changed by different types of programs. Organizations can use the information in this table to guide them in choosing what factors they should focus on, given their goals, capabilities, and resources.

Table 3-1 rates the factors' amenability to change as follows: those that are impossible or extremely

difficult for most teen pregnancy and STD/HIV prevention organizations to change, although they may be able to do so by working with other agencies; those that are difficult for most organization to change unless they have special initiatives or capabilities (e.g., youth development activities or mental health services); and those that are most directly related to sexuality and reproductive health and thus most amenable to change by organizations targeting teen pregnancy and STD/HIV.

The only factors that, cannot be changed are biological. In addition, factors stemming from community disorganization cannot easily be changed by organizations that focus primarily on reproductive health, although sometimes collaboration with community or state agencies may bring about improvements. Other intractable factors relate to family structure, past events in the teen's life, and parents' sexual behavior. (Other agencies may be able to ameliorate some of the consequences of these factors, however.)

Some factors that cannot be easily changed by most pregnancy and STD/HIV prevention organizations can be changed with intensive youth development programs or other special services, including the following:

- ☆ Educational and counseling programs for parents that help them monitor their teens more appropriately, teach them to discourage their teens from having romantic involvements with much older partners, or urge them to emphasize to their teens the importance of doing well in school.
- ☆ Intensive counseling programs for families to improve the quality of family interactions, to increase communication, and to enhance connectedness generally.
- ☆ Intensive counseling programs for emotionally distressed teens that reduce stress, depression, or risk of suicide.
- ☆ Effective alcohol and drug abuse prevention programs for teens, parents, or both.
- ☆ Programs for parents about teen sexuality that help them communicate their values about sexual behavior and decision-making.
- ☆ Career education programs for teens that help them set—and pursue—educational and career goals.
- ☆ Tutoring programs that increase teens' attachment to school, improve their performance in school, and encourage them to pursue higher education.
- ☆ Intensive entrepreneurship programs that improve performance in school.
- ☆ Intensive arts and creative expression programs that increase performance in school and connectedness to school.
- ☆ Intensive service learning programs that bolster connectedness to school, improve school performance, and have other positive effects.
- ☆ Mentoring programs that increase attachment to parents, other adults and school, and decrease alcohol and drug use.
- ☆ Sports programs for girls that increase their participation in athletics.
- ☆ Other school-sponsored programs that encourage teens to become actively involved in school activities.
- ☆ Faith-based programs that encourage teens to be more involved in their faith communities and to learn the values of those communities, especially about sexuality.
- ☆ Comprehensive community-based programs that address multiple risk and protective factors.

Research has shown that most of these programs can affect risk and protective factors, but unless a program has certain important characteristics, it may not be effective [7]. In some of the examples above, particular program activities may be less important than involving young people actively and intensively in activities over a long period of time or forming close connections with adults.

The risk and protective factors that can be most easily changed by teen pregnancy and STD/HIV prevention programs are the sexual ones—that is, the sexual knowledge, values, perception of peer norms, motivation, and self-efficacy (confidence in their skills) of teens themselves, their partners, or their peers. Chapters 6 and 8 demonstrate that some sex and STD/HIV education programs, as well as other kinds of programs, can change these factors, thereby delaying the initiation of sex, reducing the frequency of sex, reducing the number of sexual partners, increasing condom or contraceptive use, or some combination of these outcomes. Logically, then, some of the programs also reduce rates of pregnancy and STD. Positive behavioral effects have been observed in a variety of program settings, including schools during regular school hours and on the weekends, community health centers, community detention centers, shelters for runaway youth, and residential drug treatment programs.

IMPLICATIONS OF THESE FACTORS FOR PREGNANCY PREVENTION PROGRAMS

The following conclusions regarding risk and protective factors should be considered when designing and targeting pregnancy and STD/HIV prevention programs:

- ☆ On the one hand, most youth are at risk of unprotected sex and pregnancy. Given that about four-fifths of young people in the United States have sex while still in their teens, and given that many of them do not always use condoms and other forms of contraception consistently or effectively, pregnancy and STD are real risks in the lives of most teens. Thus, *all* teens need appropriate education about the value and benefits of delaying sex as well as accurate information about condoms and other forms of contraception. And all teens who become sexually active need access to reproductive health services.
- ☆ On the other hand, *some* teens are at much greater risk than others, and understanding the factors outlined here can help programs target high-risk teens with more intensive—and effective—interventions.
- ☆ Risk and protective factors should provide the basis for developing programs to prevent teen pregnancy and STD/HIV. Programs should focus on factors that are strongly and causally related to sexual risk-taking *and* that are amenable to change by the program. Table 3-1 lists factors meeting those conditions.
- ☆ Risk and protective factors should also provide the basis for identifying teens at greatest risk of unprotected sex. Some of the most important factors are readily measurable (gender, age, ethnicity, family income, school performance, and engagement in other risk-taking behavior) and can be used to identify teens most in need of help.
- ☆ The factors that influence teens' sexual behavior and decision-making are rooted in communities, families, schools, faith communities, friends and peers, romantic partners, as well as in teens themselves. Some of the factors also involve teens' relationships with these important individuals or organizations in their environment. Factors that increase the likelihood of teen pregnancy and STD/HIV are risk factors, whereas those that lower the likelihood are protective factors. Some factors influence sexual behavior directly, while others affect it indirectly.
- ☆ The majority of factors fall into one of four themes: biological factors such as age, physical maturity, and sex; disadvantage, disorganization, and dysfunction in the lives of teens and their families, peers, and communities; sexual values and norms expressed or modeled by teens themselves or by their families, romantic partners, peers, faith communities, schools, and communities; and teens' connection to groups or institutions that discourage risky sexual behavior, encourage responsible behavior, or both.
- ☆ Because so many factors affect teen sexual behavior, few individual factors have a large impact. Consequently, there is no simple, easy-to-implement prevention program—no

magic bullet—that will substantially change adolescent sexual behavior and lower pregnancy and STD/HIV rates. Few programs, after all, can modify more than a few risk or protective factors at a time.

☆ Because teens' sexual beliefs, attitudes, perceived norms, confidence in their abilities, intentions, and actual skills are more strongly related to their sexual and contraceptive behavior than most other, nonsexual factors, and because these sexual factors can be modified, prevention efforts should include sex and STD/HIV education programs as well as other interventions that address these factors. Given that teens' sexual beliefs, attitudes, and behavior are affected by their parents, siblings, and peers, prevention efforts should also encourage these groups to model appropriate sexual behavior, as well as encourage the media to present more responsible models of sexual behavior.

☆ Some nonsexual risk and protective factors are modestly related to pregnancy and STD, and some of them can also be modified. Interventions should address such factors.

☆ Because of the substantial variety among important risk and protective factors, organizations with diverse missions can help reduce the rates of teen pregnancy and STD. Organizations that traditionally focus on teen sex and reproductive health can most effectively address sexual factors, while those with broader missions can emphasize nonsexual factors.

☆ To reduce pregnancy and STD markedly, communities may have to address many risk and protective factors among different groups (e.g., teens, their families, schools, and communities), and they may have to address both sexual and nonsexual factors. In practice, this may mean that a patchwork of programs can be effective at the community level, if each addresses a specific set of factors that in the aggregate improve most of the important risk and protective factors.

☆ ☆ ☆

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