

Original Studies

Why Lightning Strikes Twice: Postpartum Resumption of Sexual Activity during Adolescence

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Abstract. *Purpose:* To describe the circumstances surrounding the postpartum resumption of sexual activity in a cohort of teenage mothers. The goal was to shed new light on the reasons why teenagers who have just given birth put themselves at risk for conception.

Methods: A racially and ethnically diverse group of 267 poor, predominantly unmarried, primiparous, 13–21 year olds was enrolled consecutively at delivery and followed through the third postpartum month. The primary outcome measure was weeks postpartum at resumption of sexual activity, further categorized as protected or unprotected. The analysis controlled for factors thought to influence the postpartum resumption of sexual activity among adult couples and the use of contraception during adolescence. The Kaplan-Meier method was used to estimate the time to end point and Cox proportional-hazards regression analysis to compute relevant relative risks (RR).

Results: By the end of the third postpartum month, 58% of the teenagers had had sexual intercourse and the majority (80%) used contraception when they did so. The median time to first coitus, 10.7 weeks, was unrelated to contraceptive use but was significantly shorter among teenagers who lived with their boyfriends (RR: 2.4; 95%CI: 1.7–3.4) and those who delivered prior to term (RR: 2.1; 95%CI: 1.3–3.6). The analysis revealed that the teenagers who did not use contraception at first postpartum sexual intercourse exhibited more theorized risk factors for conception than those who did and those who remained sexually abstinent.

Conclusions: This new empirical evidence that coital activity resumes soon after delivery should dispel the normative belief that contraception is unnecessary during the puerperium. Early contraceptive vigilance may also decrease the frequency and rapidity with which teen mothers conceive, as the differences in the prevalence of teen pregnancy risk factors we uncovered suggest that decisions about using contraception (not sexual intercourse) determine the risk of rapid repeat conception. Teens with

live-in boyfriends and premature babies are especially apt to benefit from the new information in this report as they resume sexual activity sooner than their peers and are less apt to use contraception when they do so.

Key Words. Teen pregnancy—Contraception—Abstinence

Introduction

The prevention of closely spaced pregnancies is an important public health goal that has been vigorously pursued for decades in the United States.¹ It is especially important to prevent second and higher order teen pregnancies because during adolescence the risk of preterm and low birth weight delivery increases, and the likelihood of completing high school, having a job, and being self-supporting decreases with each additional birth.^{2–5} Moreover, because the amount of time and resources that can be spent on the first child diminishes with each successive pregnancy at this age, the risk of developmental delays, accidental and non-accidental trauma, school failure, delinquency, and teen pregnancy in the next generation also parallels the number of children in teen-headed families.^{2,3} Although it is difficult to distinguish between the causes and consequences of rapid repeat conception during adolescence,^{2–5} the strong epidemiological association between parity and this array of adverse maternal, infant, and child outcomes has made achieving an inter-pregnancy interval of at least 2 years a national priority.¹ Unfortunately, the frequency and rapidity with which teenage mothers become pregnant remains one of the most perplexing diagnostic and therapeutic challenges health care and social service providers face in the US.²

Empirical evidence that following delivery almost all teenagers want to avoid conception, have aspirations for their futures that are as incompatible with

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closely spaced adolescent childbearing as to those of their never-pregnant peers, and receive contraceptive counseling and supplies on repeated occasions, suggests that for the majority of inconsistent teenage contraceptive users pregnancy is a “wake-up call” that they have both the means and the motivation to respond to.⁶⁻⁹ Thus, it is difficult to understand why even among those who enroll in comprehensive, multidisciplinary programs that provide access to contraceptives and promote their use as a means of attaining personally desired professional goals, the risk of conception is as high during the first 6 postpartum months as it is during all of adolescence for never-pregnant teenagers.^{2,7-10}

Because only a minority of sexually active, inadequately contracepting teens become pregnant during adolescence,¹¹ it is possible that those who do so are simply the most fecund and that this tiny core group of teen conceivers continues to make a disproportionate contribution to the cost and the magnitude of the teen pregnancy epidemic in the US, because the same level of contraceptive risk taking is associated with a higher likelihood of conception among teen mothers. However, the fact that interventions that decrease teen births in the second postpartum year are ineffective in the first,¹⁰ suggests that there are psychosocial and behavioral roots as well as biological ones.

To shed new light on this conundrum we studied the circumstances surrounding the postpartum resumption of sexual activity in a cohort of teenage mothers, all of whom received extensive prenatal education about contraceptive options, stated that they wanted to remain non-pregnant for at least a year after delivery, and seemed to understand the necessity of consistently using an effective method of contraception to do so. An extensive literature review uncovered no information about the factors associated with the resumption of sexual activity after the birth of a baby during adolescence. However, the results of prior studies indicate that characteristics of the postpartum environment, pregnancy, and romantic relationships (Table 1) influence when adults do so,¹²⁻¹⁶ and whether sexually active teen mothers use contraceptives.^{2,6-9,17,18} We focused on the first 3 postpartum months because we could find no information about the sexual and contraceptive behavior of teenage mothers during this period and the risk of adverse medical and psychosocial consequences is especially great when women become pregnant again so soon.^{4,19,20}

Methods

Subjects

Study subjects were enrolled consecutively between January 1, 2003, and April 15, 2004. The sample

Table 1. Factors That Influence The Timing of the First Postpartum Coitus and Contraceptive Use

Characteristics of the mother and her postpartum environment	
Age	
Race/ethnicity	
Gravidity/parity	
Living arrangement: with biological parent/in own apartment/other	
Education: high school graduate or equivalent/enrolled/drop-out prior to high school graduation	
Education plans: none/high school graduation or equivalency/post-high school trade or college	
Career plans: mother/other	
Family plans: when couple wants to have another child	
Reason for not using contraception prior to the index	
Characteristics of the pregnancy and delivery	
Subjective impression: good/bad and easier/harder/as expected	
Prenatal care: CAMP/none or adult-oriented care	
Delivery: Vaginal (no further differentiation between spontaneous and instrumental)/cesarean	
Infant at birth weight: low birth weight (<2500 grams)/normal	
Infant maturity: preterm (<37 completed weeks gestation)/term	
Nursery type: Level I/Level II or III	
Characteristics of pertinent romantic relationships	
Relationship with the father of her baby: none or platonic/dating/co-habiting or married	
Relationship with other boyfriends: none or platonic/dating/co-habiting or married	
Age of current boyfriend(s)	
Age difference between partners	
Relationship duration(s)	

consisted of a racially and ethnically diverse (22.8% White, 37.1% Black, 37.8% Hispanic, and 2.3% other) group of 267 poor (89% Medicaid recipients), predominantly unmarried (91%), primiparous (73%), newly delivered 13–21-year-olds (mean \pm Sd: 18.3 \pm 1.7 years), who were not incarcerated, retained custody of a living child, and made at least one visit to the Colorado Adolescent Maternity Program (CAMP), during the first 3 postpartum months. Most participants also obtained prenatal care in CAMP (87%), had uncomplicated pregnancies, and gave birth vaginally at term to healthy, well grown infants, the majority (89.6%) of whom went home in 1 to 2 days. Although most study participants described their pregnancies as good (90%) and easier or about what they expected (72%), none wanted to become pregnant again during the first postpartum year. Rather, the majority said that they (91%) and their boyfriends (87%) planned to postpone further childbearing for at least 3 years. Finally, despite a high drop-out rate (43%), only a minority (7%) of these teenagers did not aspire to graduate from high school and at delivery approximately half still had definite plans to pursue careers in addition to motherhood. The study was approved by the University of Colorado Health Sciences Center Institutional Review Board.

Setting

CAMP is a comprehensive, multidisciplinary prenatal, delivery, and postnatal care program, located in a large, urban, teaching hospital.⁷ The program utilizes a case-management format to combine the professional services of physicians, nurse midwives, physician's assistants, home visiting case managers, a social worker, and a dietitian so that teenage parents and their children can receive the full continuum of maternity, delivery, and acute and preventive child and teen care simultaneously from a single team of health and social service care providers.^{7,21} The CAMP intervention is based on the premise that the family is the basic social unit and that impoverished teens require additional encouragement and support to have healthy babies, engage in development-promoting activities, postpone future childbearing, and become nurturing parents. Participants are treated as resources to be developed (not problems to be managed) and family involvement is strongly encouraged so that prevention messages are as constant and long lasting as possible and the teens do not feel caught in a crosscurrent in which the advice they receive from the program conflicts with the advice they get at home. The goal is to reduce the incidence of adverse pregnancy outcomes and repeat teen pregnancies and to increase the number of young parents who graduate from high school and become productive members of their communities and happy, non-abusive mothers and fathers. To promote staff-patient interaction and facilitate the implementation of individual care plans, parents and children are seen together and appointments are scheduled within a week of delivery, monthly for 2 months, every other month for the next 4 months, and then at 3-month intervals until the child is 2 years old.

The components of the postpartum program were selected with the expectation that the intervention would prevent rapid repeat pregnancies directly by simplifying access to preventive health and social services and indirectly by discouraging school dropout and encouraging the pursuit of careers that foster competency and self-sufficiency and are incompatible with closely spaced adolescent childbearing.^{4,7-9,21-24} At each clinic visit, providers emphasize the advantages of completing high school and delaying childbearing beyond adolescence rather than the disadvantages of not doing so, stress that pregnancy prevention is not an end in itself but a means of attaining a desirable life style, and make every effort to enhance family and community support for this goal. Periodic risk assessments include a systematic appraisal of life domain specific expectations about the effects of childbearing on life course development. This helps the staff develop a differential diagnosis for inconsistent contraceptive use and tailor

the intervention to address treatable causes of sexual risk taking. Finally, because lapses in contraceptive vigilance are inevitable, providers verify that the teens have prescriptions for emergency contraceptive pills.

Data Collection and Definition of Variables

At enrollment all study participants completed a precoded, self-administered, multiple choice questionnaire that was written at a fourth grade reading level and collected information about the social context of the pregnancy, with emphasis on commonly cited demographic, psychosocial, and behavioral risk factors for preterm delivery and rapid, repeat conception during adolescence.^{2,6-9,17,18} At each subsequent postpartum visit, participants completed a brief questionnaire that asked about sexual activity, the consistency of contraceptive use, and the types of contraceptives used during the retrospective 2 months. Additional medical and outcome data were obtained by reviewing the participants' medical records.

Outcome Variables

The primary outcome measure was weeks postpartum at resumption of sexual activity. Responses to the questions about contraceptive use were used to further categorize this initial sexual encounter as protected or unprotected. Teens who had tubal ligations, obtained injections of DepoProvera within 3 weeks of delivery, and/or reported use of barrier methods, were considered to be protected during the puerperium. However, estrogen-containing contraceptives are usually not fully effective until they have been used for 3 to 4 weeks and in keeping with the standard of care at our institution, CAMP patients are instructed to start using these agents 3 weeks after delivery and to have intrauterine devices (IUD) inserted after a 6-week postpartum check-up. Thus, teens who relied exclusively on these contraceptives were classified as unprotected during the puerperium. Those who only used contraceptives that have been associated with more than a 10% risk of accidental conception during a year of typical use, (i.e., rhythm, douching, withdrawal, and emergency contraceptive pills),²⁵ were classified as unprotected during the entire observation period. Sexual and contraceptive behavior was self-reported and not otherwise validated as the reliability of this method of inquiry has been established in comparable populations.^{26,27}

Explanatory Variables

The factors that influence the sexual and contraceptive behavior of teenage mothers and the postpartum resumption of sexual activity among adult mothers have been studied extensively and variables from numerous domains have been mentioned.^{2,7-9,12-18}

This analysis controlled for the most salient and frequently implicated factors (Table 1).

Data Analysis

The questionnaire data were screened for accuracy and analyzed with SPSS/PC (version 12; 2004). Summary statistics were used to describe the study population and Student's *t*-tests, chi-square analyses, and ANOVAs to compare the characteristics of sexually active teens who did or did not use contraception at first postpartum sexual intercourse to their abstinent peers. Next, survival analysis (Kaplan-Meier method) was used to estimate the rate at which sexual relations were resumed following delivery and the effects of the explanatory variables. The time to first intercourse was considered the time to the end point. To ensure equivalent follow-up times the observation period for each participant was truncated at approximately 3 months (12.9 weeks). Data on sexually abstinent teenagers was censored at the last postpartum visit during the 3-month observation period, with those who had not had sexual intercourse by the end of the 12th postpartum week classified as non-sexually active and censored at this point. Kaplan-Meier estimates of survival were based on the number of non-sexually active teenagers at the end of the observation period. Survival curves were compared with the log-rank test and Cox proportional-hazards regression analysis was used to study the combined effect of the relevant explanatory variables and to compute RR for the sex-free survival. Because we had no basis for choosing one variable over another, explanatory variables for which there were significant ($P < 0.05$) group differences at the bivariate level were allowed to enter this forward, step-wise analysis one at a time on the basis of the statistical significance of their association with postpartum sexual intercourse status. Adjusted RR and their 95% confidence intervals were calculated from the Cox regression model coefficients for each variable.

Results

At delivery, approximately half of the study participants lived with at least one biological parent, two thirds described their relationship with the father of the baby as more than platonic, and two had new boyfriends. Although only 39% of the teenagers had a live-in boyfriend, Kaplan-Meier probability estimates revealed that coital activity resumed rapidly (i.e., at a median of 10.7 weeks post partum, range 0.4–12.9 weeks), reaching 24.4% by the end of the puerperium and 58.4% by the end of the observation period (Fig. 1). Teenagers who had sexual intercourse during the first 3 postpartum months were older than

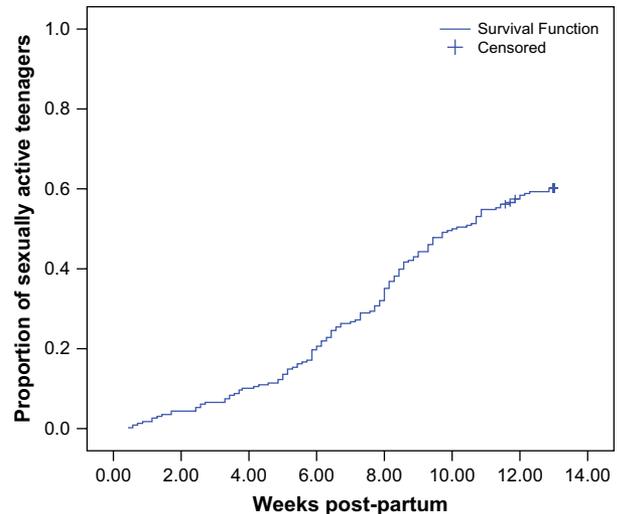


Fig. 1. Timing of the resumption of sexual activity.

those who did not and less apt to be under 17 years of age at delivery (13.9% compared to 24.2%; $P < 0.05$). They were also more likely to be living in their own house or apartment (31% compared to 18%; $P = 0.02$) and with their boyfriends (53% compared to 24%; $P < 0.0001$). They were less apt to be living with a biological parent (44% compared to 60%; $P = 0.01$), to be enrolled in school (21.6% compared to 37.5%; $P = 0.01$), and to plan to return to school during the next 6 months (47% compared to 65%; $P = 0.03$). The circumstances antedating the index conception also differed between the two groups of teenagers, with those who resumed sexual activity during the observation period more apt to have known the father of their baby for at least 6 months prior to conception (80.3% compared to 65.5%; $P = 0.02$) and to say they had not been using contraception at the time of the index conception because they “didn’t mind” or wanted to conceive (36% compared to 23%; $P = 0.04$). Finally, teenagers who began to have sexual intercourse again within 3 months of delivery had shorter gestations than those who did not (mean \pm SD = 38.7 \pm 2.4 compared to 39.4 \pm 1.5 weeks; $P = .004$) and were twice as likely to deliver prematurely (12% compared to 5%; $P = 0.09$). The Kaplan-Meier probability estimates indicated that when considered individually these factors also influenced the time to first postpartum sexual intercourse significantly (data not shown). The two groups of teenagers did not differ with regard to delivery type, subjective impression of pregnancy, age of partner or age difference between partners, future family plans, or the frequency with which members attributed their failure to use contraceptives prior to conception to method failures, contraceptive side effect or fertility concerns, and lack of access or money.

In the Cox proportional-hazards model, significant main effects were only observed for having a live-in boyfriend (RR: 2.4; 95%CI: 1.7–3.4) and a preterm baby (RR: 2.1; 95%CI: 1.3–3.6). Fig. 2A shows that 75.5% of teenagers who lived with a boyfriend had sexual intercourse within 3 months of delivery (median time to first postpartum intercourse: 8 weeks) compared to 46.7% of those who did not (median time to first postpartum intercourse: 10.5 weeks). The experience of a preterm delivery had a similar effect on the postpartum resumption of sexual activity. Fig. 2B shows that 76.1% of teenagers who gave birth prior to term had sexual intercourse during the observation period (median time to first postpartum intercourse: 7.3 weeks) compared to 56.8% of those who did not (median time to first postpartum intercourse: 10.9 weeks).

Almost everyone (93.5%) planned to use a non-coital dependent method of contraception following delivery (38% said they would use Depo-Provera, 35.5% pills/patch/ring, 19.5% the IUD, and 0.5% tubal ligation or vasectomy) and most (89.2%) either did so or remained abstinent. Subsequent Kaplan-Meier analyses revealed that contraceptive use did not influence the time to endpoint and failed to identify any explanatory variables that significantly influenced the timing of protected as opposed to unprotected sexual intercourse (data not shown). However, ANOVAs revealed some important group differences, especially between the minority of teenagers who did not use contraception at first postpartum intercourse and their sexually abstinent peers (Table 2). Specifically, the post hoc analyses indicated that teenagers who had unprotected sexual intercourse were less apt

to be living with a biological parent and more apt to be living in their own home with a boyfriend. These teens were also less apt to be enrolled in and to plan to return to school during the next 6 months and more apt to have dropped out prior to high school graduation, to attribute their failure to use contraception effectively prior to the index conception to their lack of desire to remain non-pregnant, and to have a relatively long-standing, deep romantic relationship with the father of the baby (i.e., to have known him for at least 6 months prior to conception and to live with him). By contrast, the only significant difference between teens who used contraception at first postpartum coitus and those who remained abstinent was that they were more apt to have live-in boyfriends. Finally, with 19% of those who did not use contraception at first postpartum intercourse, 10% of those who did, and 5% of those who remained sexually abstinent giving birth prior to term, there was a clinically impressive, albeit statistically insignificant ($F = 2.2$; $P = 0.1$), difference in the proportion of preterm deliveries between the three groups.

Discussion

Inconsistencies between women's stated desire to avoid conception and their failure to use readily available contraceptives have baffled the professionals who care for them and study their behavior since the advent of the modern contraceptive era.^{24,28–31} Why a teenager who has just given birth to a baby would have unprotected sexual intercourse and put herself at risk for conceiving another is especially difficult to understand. We studied the circumstances surrounding

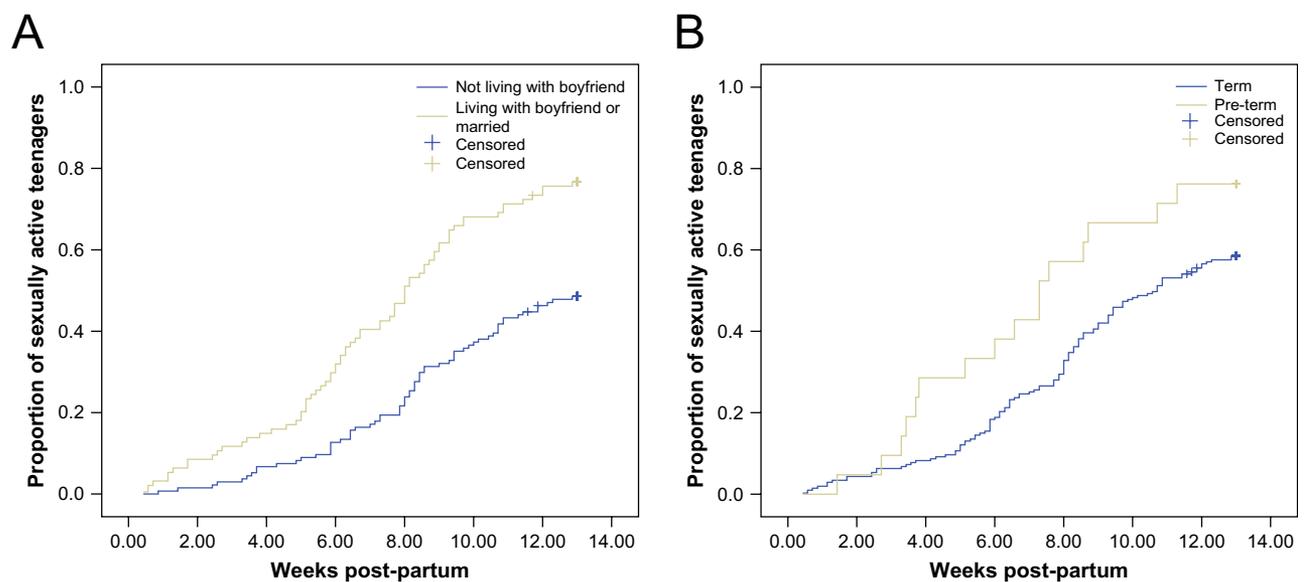


Fig. 2. Timing of first post-partum sexual intercourse in relation to having a live-in boyfriend (Panel A) and having a preterm infant (Panel B)

Table 2. Characteristics of Teenagers by Sexual Activity and Contraceptive Use Group

Characteristic (Significance [*])	Study Group	Characteristic Present	Post Hoc Comparisons	Post Hoc Significance
Living arrangement				
With a biological parent (F = 3.8; p = 0.02)	Unprotected sex	33%	Unprotected v. Protected	ns
	Protected sex	46%	Unprotected v. No sex	0.04
	No sex	60%	Protected v. No sex	ns
In own apartment/house (F = 3.4; p = 0.02)	Unprotected sex	41%	Unprotected v. Protected	ns
	Protected sex	28%	Unprotected v. No sex	0.05
	No sex	18%	Protected v. No sex	ns
School status				
Enrolled (F = 6.1; p = 0.003)	Unprotected sex	4%	Unprotected v. Protected	ns
	Protected sex	26%	Unprotected v. No sex	0.002
	No sex	38%	Protected v. No sex	ns
Dropped-out (F = 6.9; p = 0.001)	Unprotected sex	77%	Unprotected v. Protected	0.003
	Protected sex	42%	Unprotected v. No sex	0.001
	No sex	38%	Protected v. No sex	ns
Resume education <6 months (F = 3.9; p = 0.02)	Unprotected sex	30%	Unprotected v. Protected	ns
	Protected sex	52%	Unprotected v. No sex	0.02
	No sex	65%	Protected v. No sex	ns
Reason for no contraception				
Did not want to avoid index conception (F = 4.2; p = 0.02)	Unprotected sex	52%	Unprotected v. Protected	ns
	Protected sex	32%	Unprotected v. No sex	0.01
	No sex	23%	Protected v. No sex	ns
Relationship with father of child				
Known >6 months prior to conception (F = 5.4; p = 0.005)	Unprotected sex	93%	Unprotected v. Protected	ns
	Protected sex	77%	Unprotected v. No sex	0.01
	No sex	66%	Protected v. No sex	ns
Living with or married (F = 13.6; p < 0.0001)	Unprotected	74%	Unprotected v. Protected	0.03
	Protected	47%	Unprotected v. No sex	0.0001
	No	24%	Protected v. No sex	0.002

*Significance of between group differences in the prevalence of characteristics by one-way ANOVA – see text for discussion.

the postpartum resumption of sexual activity in a cohort of teenage mothers, all of whom received extensive prenatal education about contraceptive options, stated that they wanted to remain non-pregnant for at least a year after delivery, and seemed to understand the necessity of consistently using an effective method of contraception to do so. Our goal was to learn why even under the most favorable research conditions and in the most intensive reproductive health care settings, in the US close to one in ten teen mothers who seem willing to use contraception in order to avoid conception give birth during the first postpartum year.^{2,7-10} Our first important finding was that a quarter of teenage mothers have sexual intercourse during the puerperium and nearly 60% do so within three months of delivery (Fig. 1). This is lower than the rate reported for adult women and we were unable to corroborate the effects that parity and mode of delivery have on the postpartum resumption of sexual activity among adults.¹²⁻¹⁶ Further comparisons with the literature were difficult as we could not find any comparable data on teens and many of the factors that influence the postpartum resumption of sexual activity in adults (i.e., maternal psychological status, breast feeding and postpartum

bleeding¹²⁻¹⁶) were not assessed, making it impossible to comment on their relevance in teens.

Only two factors, living with a boyfriend and preterm delivery, were significant independent predictors of time to first postpartum coitus. As shown in Fig. 2, in these circumstances it can be anticipated that three out of four teenagers will resume sexual activity during the first 3 postpartum months and that the median time to first postpartum intercourse is likely to be only 7 to 8 weeks. It is not surprising that time to first coitus is shortest among teens who live with their boyfriends. Even without clear evidence of causality, the etiology of the association is intuitively obvious. Moreover, marriage and co-habitation are among the factors that influence the postpartum resumption of sexual activity in adults.¹²⁻¹⁶ However our finding that teenagers who deliver prior to term resume sexual activity sooner than those who deliver at term is new. An association between closely spaced childbearing and preterm delivery has been reported among adult women.^{19,20} However, research has yet to elucidate if this relationship is causal or a reflection of shared risk factors. Given the strong epidemiological evidence that preterm delivery occurs in successive pregnancies,^{4,32,33} our finding that teenagers

whose first postpartum coitus was unprotected were nearly four times more likely to have delivered prior to term than those who abstained from sexual intercourse during the first 3 postpartum months, (i.e., 19% and 5%, respectively), suggests that preterm delivery might be a risk factor for short inter-pregnancy interval, not vice-versa. A reciprocal relationship is also plausible, as the psychological stress of a preterm birth could predispose women to early, unprotected sexual intercourse and the physiological stress of closely spaced conceptions could predispose them to preterm delivery. Clearly, a longer period of follow-up is needed to test the validity of these inferences and to determine which of the two is the chicken and which the egg.

Our second important finding was that the failure to use an effective method of contraception at first postpartum coitus is associated with many characteristics that are usually considered risk factors for teen pregnancy, whereas the resumption of sexual activity during the first 3 postpartum months is not associated. The data in Table 2 show that previous findings relating teen contraceptive use to living arrangements, educational status and plans, reasons for not using contraception prior to conception, and characteristics of romantic relationships^{2,5-9,17,18,24,34-37} were confirmed in this population. By contrast, teenagers who used contraception the first time they had sexual intercourse after delivery did not differ from those who remained abstinent during the observation period with regard to any of these theorized risk factors for conception during adolescence. That fact should put to rest the idea that sexual activity per se is pathogenic, allowing us to focus, as our European colleagues do, on preventing the morbidities everyone agrees unprotected sexual activity creates, rather than promoting abstinence and running the risk of creating an atmosphere that constrains knowledgeable teens from acting on their intentions to delay childbearing.^{31,38-40} While the general trend toward decreased sexual activity among American teenagers has undoubtedly contributed to the decline in the US teen pregnancy rate, given the striking contrast between the success of the European and US approaches to sex education,^{31,38-42} the fact that nearly 60% of the teenage mothers we studied had sexual intercourse within 3 months of delivery makes the need to institute an effective contraceptive regime prior to discharge from the labor and delivery ward or at the first well baby visit undeniable.

Here, our finding that all key correlates of the failure to use contraception at first postpartum sexual intercourse represent relatively transient personal and social characteristics rather than the more enduring demographic ones that shape the structure of society is especially encouraging because it reinforces the

impressions that like other types of risk-taking during adolescence, contraceptive risk-taking is not a stable personality trait but a potentially modifiable, situational behavior the occurrence of which is apt to be conditioned by immediate circumstances.^{24,28-31,34-37} Although, like other biomarkers of risk, pregnancy seems to be a pivotal event that creates a “teachable moment” during which women this age particularly open to behavioral change,^{6-9,18} due to the combined impact of childbirth, medical and social taboos against having sexual relations during the puerperium, and the desire to lose weight, many deny the need for contraception at least until the “6-week postpartum checkup.” Because the findings from this study suggest that circumstances often change more rapidly than anticipated, even those who sincerely want and plan to postpone the birth of their next child for “some years” are apt to find their prophylactic options limited to relatively ineffective, difficult to use methods like condoms, withdrawal, emergency contraceptive pills, douching, wishful thinking, and prayer, unless steps are taken to dispel the normative belief that contraception is unnecessary during the puerperium because most women do not have sexual intercourse prior to the 6-week postpartum check-up.

To this end we encourage providers to include Figs. 1 and 2 in their antenatal counseling. However, poor, inner-city teenagers give pregnancy prevention a low priority ranking.³⁷ Thus discussions about postpartum contraceptive options must also frame the advantages of delaying the next pregnancy beyond adolescence and the opportunity costs of not doing so in a new light.

That is, in a context that helps young mothers who grow up in the resource-depleted neighborhoods where teen pregnancy is endemic understand that postponing the birth of their next child beyond high school graduation is not an end itself but a means of attaining the lifestyle their ardent demands for better educational and job opportunities suggest they want.^{23,37} Moreover, because sexual relations typically fulfill a variety of goals unrelated to pregnancy at this age,⁴³ and some teenagers have difficulty reasoning deductively about emotionally charged issues like childbearing,⁴⁴ whereas others are simply too impulsive⁴⁵ and/or present-time oriented to think about the long-term consequences of their actions, any effort to prevent new teen mothers from putting themselves at risk for pregnancies almost none of them want and almost all of them could prevent, is apt to be futile if it does not include an antepartum assessment of motives for sexual relations, cognitive capacity, and impulsivity.

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