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# EXPLORATION OF ROMANTIC RELATIONSHIPS IN ADOLESCENT FEMALES

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EXPLORATION OF ROMANTIC RELATIONSHIPS
IN ADOLESCENT FEMALES

A DISSERTATION APPROVED FOR THE
GRADUATE COLLEGE

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Dedication

To Edward Brandt, Jr.

It was a privilege to have your support and encouragement until it was your time to leave. Your influence continues.

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TABLE OF CONTENTS

LIST OF TABLES

Abstract

Adolescence is a time to explore and develop romantic relationships. Glamorized sexual messages and images bombard youth as they struggle to develop their sexual identity. The darker side of romance that includes teen pregnancy, STDs, and emotional pain is rarely portrayed. Because adolescent females shoulder the burden of unwanted sexual outcomes, an exploration of their experiences, both positive and negative, is the focus of this study.

Current literature contains demographic information about who is at risk for unwanted pregnancies and Sexually Transmitted Diseases (STDs), but little is known from the adolescent females' perspective, about their sexual experiences and even less about normal romantic ideation which drives sexual behavior. This qualitative study utilized ethnographic interviews to explore the experiences of 28 females ages 19-29 from four cultural backgrounds including Euro-American, African-American, American Indian, and Latina. The influence of families, peers, school, and sex education programs was explored for positive and negative experiences. Advice about romantic development to younger adolescent females was sought to gain insight into their development and how to better assist adolescent females in developing healthy romantic relationships. A multi-staged data analysis of the interviews was used to find similarities and differences among the subjects and cross culturally.

Discussion of romantic behavior occurred in less than half of the nuclear families. Extended family such as aunts, uncles, and grandparents were named as significant role models by most participants and were frequently described as sources for support and occasionally available for discussion of romantic relationships. Peers

were perceived to be sexually active and most behaved in a similar manner. Euro- and African-Americans placed more importance on peer groups. Reproduction was most frequently learned in the school system, rather than from family and peers. The programs were reported as woefully lacking in comprehensiveness. This study calls for policymakers to fund sex education programs for adolescents with potential participation from parents, extended family, and peers. The curriculum should address age-appropriate strategies for discussing romantic and sexual behavior. Additionally, guidelines for monitoring activities and use of new technologies that pose higher risks in early adolescence are most important. Health educators and healthcare providers can utilize these strategies when working with adolescents, families, and peers to improve their romantic relationships and decrease teen pregnancies and STDs.

# CHAPTER I – INTRODUCTION

My dissertation focuses on adolescent females and family, educational and peer influences on the decision-making process with regard to whether, with whom, and when to engage in a romantic relationship that may include sexual intercourse. This decision-making process is very important in determining how adolescent females will succeed in life, in completing high school, and going to college and beyond. Having conducted interviews with post-adolescents to discuss their adolescence, I have attempted to address gaps in the literature on female adolescent development. My dissertation also explores the historical, social, political, and economic contexts that shape these young women's lives in the Oklahoma City and Tulsa, Oklahoma, metropolitan areas.

Adolescence is a time to break from family and develop one's own identity. Parents have always struggled with the methods which adolescents use to demonstrate their rebellion and separation. We had beatniks in the 1950s, hippies in the 60s and 70s, and Goth in the 80s and 90s. Each generation's expression of self was often a reflection of the media, politics, and the new technologies available which created unique sub-cultures within American society. Components of these adolescents' sub-cultures usually included forms of body art, distinct music revolutions, and new ways of communicating within the adolescent group and to greater society.

Body art is a form of expression that dates back to ancient times, but it has experienced its most recent resurgence in the last ten years. Modifying the body is particularly appealing to adolescents who are struggling to create their own identity with their changing bodies. The percentage of adolescents who are tattooed or pierced

ranges from 10-25% (Carroll & Anderson, 2002), and the prevalence rate for adolescent females is 7.2% (Suris, Jeannin, Chossis, & Michaud, 2007).

Authorities have researched motivating factors for body art and determined that there are numerous reasons for the practice. Some people alter their bodies to express an art form similar to wearing an accessory and belonging to a group, while more negative interpretations include a type of alienation from society and/or a form of self-destruction and mutilation (Carroll & Anderson, 2002). Other studies assert that those who obtain tattoos and piercings are more likely to display other risky behaviors such as use of illicit drugs, risky sexual activity, and suicide (Suris, et al., 2007).

Another element of the adolescent culture is music. On the average, American adolescents listen to music or watch music videos four to five hours a day. Music is heard from the computer, through personalized radio stations, and streaming radios. It is heard on personal listening devices such as portable MP3 players and cell phones while also being accessible on satellite, HD, and radio. As if these options were not enough, music can still be bought on compact discs (CDs). Music has the potential to affect mood, define groups, and alter dress. Music is the center of much conversation among adolescents and provides the ambiance for most adolescent social gatherings. Although many scholars believe television is the most influential media source for adolescents, music receives more time and attention (Roberts & Christenson, 2008). The playtime that music has in the ears of adolescents gives it much power to suggest behavior through lyrics and rhythms.

While music and body art are unique to each generation, they have had fairly consistent opportunities to influence adolescents. It is the communication modalities of

the last ten years that have provided adolescents with exposure to content and situations that were unavailable to previous generations. In our current global society, it is estimated that nearly 90% of teens are online, 87% have personal cell phones, and 55% have an MP3 player (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2008). These new technologies place virtual sexual opportunities at the fingertips of adolescents. The internet provides access to pornography and sexual images that were not readily available even ten years ago. Recent survey research by The National Campaign to Prevent Teen and Unplanned Pregnancy (2008) explored how many teens are texting or posting nude (or semi-nude) pictures of themselves. The survey reported that 22% of teenage females are participating. Many parents have provided their teens personal cell phones for safety purposes and for the convenience of parental monitoring. It is ironic that this same technology can place the teen at risk for exposure to risky sexual behavior.

The new technologies of each generation allow adolescents creative, and possibly harmful, ways to express themselves sexually. Additionally, with the new technologies, society is bombarded with information about other people's romantic relationships and sexual activities. For my study, romantic relationships are defined as relationships involving amorous emotions exchanged between two people. Romantic relationships may involve sexual activity, but it is not a necessary element. Relationships that involve sexual activity without amorous emotions are not considered romantic relationships.

Adolescent romantic behavior is a focus of popular culture and is often glamorized in our society (Collins, 2003). This fascination is oriented toward finding

the right partner and living happily ever after. Body art, music, and communication technologies are intertwined in adolescent romantic relationships.

Popular culture can contribute to a much darker side of adolescent romance which results in poor decision-making. For this study, decision-making will be defined as the ability to think abstractly, reason, and consider individual and social consequences of problems. Adolescent romantic behavior can lead to teen pregnancy, sexually-transmitted diseases (STDs), and significant emotional pain.

In 2006, 435,427 infants were born to mothers aged 15–19 years, a birth rate of 41.9 live births per 1,000 women in this age group. More than 80% of these births were unintended. Although pregnancy and birth rates among girls aged 15–19 years had declined 34% since 1991, birth rates increased for the first time in 2006 (from 40.5 per 1,000 women in this age group in 2005 to 41.9 in 2006) (Center for Disease Control and Prevention, 2008). Oklahoma was ranked 8$^{th}$ in the nation for teen pregnancy in 2006. The birth rate was 59.5 per 1,000 females (Oklahoma State Department of Health, 2008). Also, it is estimated that one in four teenage girls (32 million) between the ages of 14 and 19 is infected with one of the four most common STDs (human papillomavirus (HPV), chlamydia, herpes simplex virus, and trichomoniasis) (Center for Disease Control and Prevention, 2008).

Teen pregnancy and STDs are two leading public health problems that should motivate healthcare providers, educators, and parents to learn how to best help adolescents navigate romantic relationships. The fast-paced, and often uncensored, communication about sexual topics challenges adults to stay attuned to the activities of adolescents.

As a clinical nurse practitioner, I have worked with adolescent females in family planning clinics. Occasionally, an adolescent female would seek health care in an effort to manage her sexual needs to prevent an unwanted outcome of her sexual behavior. However, many of my clients were seeking health care for unwanted pregnancies and STDs which represented negative outcomes of their sexual activities. For my clients, the burden of these health issues rested very heavily on them as opposed to their male sexual partners. Frequently, their diagnoses resulted in an overwhelming sense of shame, and they feared disapproval from their loved ones. The unwanted pregnancy diagnosis had a progressive reaction: initial shock, a sense of responsibility, and the assumption of a burden to care for a new life. The STD diagnosis left females in disbelief that their partners had exposed them to a venereal disease, which created a feeling of betrayal.

It was a result of working with these two contrasting groups of females that triggered my desire to look more deeply at the developmental journey of adolescent females as they explored romantic activity. From my day-to-day responsibilities as a nurse practitioner, I witnessed innate differences between these two groups of females and wanted to better understand how these differences had been created by looking at their culture, race, family, and peer networks. However, very little research existed for me to draw on since rarely has the concept of adolescent sexuality been explored in the context of the above factors (Cavanagh, 2007).

Due to gaps in the literature, I wanted to interview young women in-depth to explore their backgrounds regarding their culture, family, and peer group in order to identify factors that influenced or motivated their romantic behavior. I wanted to know

their individual stories about their emotional pain and conquests in order to better understand how they navigated their romantic relationships and how they made decisions about their sexual health within those relationships. In the 28 interviews I conducted, all had remarkable stories that ranged from informed, healthy decision-making to uninformed and dangerous. The following three summaries of the interviews are meant to illustrate how varied the participants were in this study in regard to culture, family, peers, and sex education. Pseudonyms have been used to protect their privacy.

Briana, a 21-year-old African-American, experienced her parents' divorce at the age of six and did not have a strong relationship with her father. Her grandmother told her that her dad had been involved with drugs, but Briana did not remember his drug use in the home. Briana's mother and three aunts all had a strong influence on her, and she reported that she felt like she had four mothers. She remembered discussing reproduction with her mom, but she had more in-depth talks about sex with her aunts who, as she reported, "probably told me more than I really needed to know."

Briana classified herself as a good student who also attended church. She had a peer group that consisted of four or five girls of whom only one was sexually active. They were all good friends, and they tried to encourage the friend who was having sex to stop. Briana remembered how much pain and disruption sex and drugs caused in her friend's life. Also, she remembered observing the emotional pain her sister, who became sexually active at the age of 16, experienced when she broke up with her boyfriend.

Briana's mother and church told her that she should remain abstinent until marriage. Her aunts, in contrast, told her she did not have to wait until marriage, but that

she should wait until she was ready to handle the emotional aspects of sexual activity. Briana lost her virginity at the age of 20, and she discussed how she made the decision based on being involved in a trusting relationship. She stated that she felt she was in a committed relationship, and that she could take care of herself if the relationship ended. It was important to her to be mature and take care of herself. It is this theme that was reflected when she was asked to give advice to a little sister. Briana emphasized that girls should make their decisions about being sexually active based on their own best interest. She also stated that adolescent identity changes significantly between the ages of 16 and 19, suggesting that a delay in sexual activity until the late teens would be appropriate. Her message reflects her own conduct in romantic relationships. The next message reflects a different path.

Cassie, a 19-year-old Euro-American, had parents who split when she was one-and-a-half, having never married. Subsequently, her dad married another woman, but her mother, with whom she lived, has divorced twice and had many boyfriends over the years. Her mother did eventually form a long-term relationship with a man. Cassie remembered seeing her mother experience a lot of emotional pain when relationships ended. Both of her grandmothers had married six times each, and she had one brother, one half-sister, and three step-brothers. Cassie stated that her family was very complicated. She gave the impression that she was embarrassed about the number of partners her mother and grandmothers had, proclaiming her family as dysfunctional.

Cassie had good school performance through grade school, high school, and now in college. When asked about her first serious boyfriend, she described herself as starting early. She stated that she began getting physically involved with the boys early

in middle school to get attention. She also stated that boys would hang around for a while if you were having sex with them.

Cassie's mother told her about reproduction when she was four or five years old. There was always a strong message to have safe sex, but Cassie felt this message carried the assumption that she would be sexually active at an early age. She recalled that everyone told her she would be like her cousin who was pregnant by the time she was 15. Cassie decided she did not want to get pregnant at an early age.

All of Cassie's friends were sexually active, and there was peer pressure to behave according to group standards. At one point, Cassie had a boyfriend whose mother provided them condoms, which they were strongly encouraged to use. She had many boyfriends at an early age and experienced the pain of dissolution of relationships. As she began to ask herself what she was doing, Cassie accepted a friend's invitation to attend her church. There, she started learning how to build healthy relationships. She decided to avoid a serious romantic relationship (one involving sexual activity) for a while because she wanted to get to know a partner before having sex, preferably waiting until marriage. Cassie believed that the church was the most stabilizing source for her since none of her family members exemplified stable romantic relationships.

Cassie strongly recommended that young females avoid sexual activity at a young age and thought it would be wise to wait until an older age to have a boyfriend. Her advice to a younger sister would be to observe the emotional pain that her friends experienced and to consider that romance at an early age often results in pain. Her final message to adolescent females was to cultivate themselves first because when they are

with males at an early age, the relationship focuses on the boyfriend. Cassie believed young females lose the opportunity to learn about and develop themselves in early romantic relationships.

Linda, a 22-year-old Latina, described her family as small. Her mother and father split shortly after she was born. She knew who her father was but had limited contact with him. Linda had siblings, aunts, and uncles, but only considered the relationship with her maternal grandparents as significant. Her grandmother raised her until she started junior high school, where she had straight A's. Linda moved in with her mother in junior high and started getting into fights at school that resulted in her involvement in legal issues. In response, her mother decided to move the family to Mexico, which caused Linda to feel isolated from her grandparents and peer group.

When Linda was living with her grandmother, she started her menstrual period without any knowledge of her anatomy and physiology. She remembered it being a frightening experience. After her menstrual cycle began, her grandmother instructed her that no one should touch her in her private places and to report to her if anyone tried. Linda believed that this message was her grandmother's way of protecting her from being sexually active. However, once Linda was living with her mother in Mexico, at the age of 14, she started a relationship with a 27-year-old man. By this point, she had dropped out of school, had no peer group involvement, and had long periods of time without adult supervision.

Despite being in school until 13, Linda recalled that she knew nothing about reproduction or sex. She started having intercourse with the 27-year-old to maintain the relationship. She did not know what caused pregnancy, let alone how to prevent it, and

found herself pregnant at the age of 15. Linda stated that it was very hard to be a young, teen mother. When asked what she would like to tell a younger sister about involvement in romantic relationships, she focused on wanting to protect her from pregnancy at such an early age. She stated that young girls need to be taught how hard it is to be a young mother. Linda also emphasized that girls need instruction about anatomy and physiology and how to prevent pregnancy, if they are going to be sexually active.

These three case studies identify a variety of factors that influence the development of romantic behavior. Briana was educated about sexual activity by her mother and aunts. She observed that early sexual activity frequently results in emotional pain. She had a peer group that predominately shared her values. Briana developed her own identity prior to becoming sexually active in late adolescence, which protected her from the problems of early sexual activity. Cassie was schooled in the art of safe sex, but she felt that sexual activity was expected at an early age before she had developed her own identity. She learned about building relationships from a peer group that was also sexually active at an early age, resulting in an emotionally painful adolescence. However, the long-term problems related to teen pregnancy were avoided. Linda was not educated about sexual activity or encouraged to develop an identity prior to engaging in sexual activity, resulting in emotional pain and the burden of raising a child at an early age. By asking for and listening to the stories of each participant's romantic relationships, the influence of culture, family, peers, and sex education was evident to the development of their sexual identity. Each case study illustrates how the females navigated through or avoided emotional pain, made decisions about sexual activity, and provided advice to younger sisters about their sexual behavior.

Of these three participants, one experienced pregnancy as a result of a risky sexual decision. At a national level, demographic data identifies the characteristics of teens at high risk to make romantic and sexual decisions that result in teen pregnancy and STDs. However, there is a gap in the social science literature on factors that influence teen decision-making processes in relation to culture, race, family, peers, teachers, and sex education programs in forming romantic relationships. One of the goals of my research is to help fill this gap. A description of the dissertation chapters follows.

In Chapter II, I present a "Review of the Literature," an examination of the most relevant literature on issues related to female adolescent development and important factors influencing decision-making in their romantic relationships. I approach adolescence as a time to develop sexual identity, which occurs along a continuum of cognitive development. This cognitive developmental process that is lacking in early adolescence affects abstract thinking and decision-making which is germane to the quality of decisions made in romantic relationships.

Theoretical frameworks by Gilligan (1982); Taylor, Gilligan, and Sullivan (1995); Tolman (2002); Fine (1988); and Carpenter (2005) focus females' perceptions of power in relationships. Adolescent females' sense of power in romantic relationships is integral to their ability to make decisions in their own best interest. Additional theoretical frameworks to be discussed include the impact of one's perception of virginity loss and one's denial of sexual desires. After establishing the frameworks that will guide this project, other relevant factors will be discussed in detail.

Culture influences adolescent development and the perception of power in romantic relationships. It is defined by gender roles, socioeconomic status, and racial stereotypes. Furthermore, the history and evolution of formal sex education impacts adolescent perceptions of reproductive health issues while also sending messages about appropriate sexual behaviors. Sex education provides the facts upon which adolescents make decisions about romantic and sexual behavior. The historical perspective of how sex education programs have been taught over the years shows the shift of responsibility to the female as a gatekeeper of sexual activity. The four major concepts taught to adolescent females in sex education classes that support this gender imbalance are fear of violence, victimization, morality, and desire. Adolescent females are taught that they are subject to violence and victimized by males in romantic relationships. If they become sexually active, their moral character is subject to scrutiny. The adolescent female is not taught about her own sexual desires, which results in the denial that such desires exist. The current perspective of how sex education is taught illustrates that these concepts are components in the existing abstinence-only, sex education curriculum.

Some adolescents learn about sex and reproduction through the schools and their families. The critical role families play in an adolescent's life is evident in the direct and indirect communication about relationships and sexuality. Adolescence is a time to develop one's own identity through a separation from family. The literature review examines the roles that families play in the development of female adolescent romantic identity. As family becomes less important during adolescence, peers take on more significance in influencing one's development of romantic behavior. The literature on

adolescent development explores the influence of peers, both same and opposite-sex. After discussing how the theoretical factors such as culture, sex education, family, and peers influence the female adolescent's sexual development, the next chapter will explore how society and the government mold perceptions of personal power through policy and legislation.

Chapter III, "Reproductive Health: Past and Present," provides a general overview of historical and contemporary socio-political issues that influence female reproductive health issues in the United States (US) and, more specifically, in Oklahoma. The societal value placed on reproductive health and the ability to access care impacts adolescent female sexual development and identity. A historical discussion takes place regarding the medical advances in reproductive health, their impact on American society, and the response of federal and state lawmakers in imposing restriction on their use.

Ginsberg (1989) conducted a community study in North Dakota which highlighted the pro-choice and pro-life ideologies surrounding the establishment of an abortion clinic. Her research presents some parallels to Oklahoma's more conservative ideology relating to abortion, emergency contraception, and access to care for the general public and for minors. Relevant federal and state legislation will be discussed in Chapter III. For example, no state or federal funds can be used to support abortions in Oklahoma, and legislation regulating medical practice for performing abortions is highly restrictive. Additionally, the legislature continues to increase the punitive measures against providers, thereby decreasing abortion access in Oklahoma.

The laws regulating access to abortion for a minor without parental consent are so restrictive in Oklahoma that it is virtually impossible for a minor to obtain an abortion during the first trimester. In order to have the procedure, the minor must appeal to the court system for judicial authorization and approval, all within the limited time available for a safe and legal procedure to occur. Emergency contraception, an over-the-counter product, which could reduce the need for abortion, is unavailable to minors in Oklahoma.

In a major public health initiative, the federal government is attempting to vaccinate young females against human papilloma virus (HPV), one cause of cervical cancer. The only way to contract the virus is through sexual activity. Oklahoma successfully passed a bill mandating that all parents of sixth grade girls submit a written statement regarding their daughters' immunization status. In contrast to the state's Abstinence-Only sex education messages, this law assumes girls need to be protected from the unwanted outcomes of sexual activity. The political climate and laws governing reproduction impact a female's decision-making power within romantic relationships. This chapter will establish the cultural and political context in which to analyze the interviews included in this study.

Chapter IV, "Methodology," describes the research methodology used in the study. Qualitative methodologies using semi-structured, ethnographic interviews were used to gather data. Additional methods included the use of genograms, modified participant observation, and life histories. Some quantitative data were used such as statistics from demographic databases, both nationally and locally. The qualitative and quantitative data used in this study can also be triangulated to support or refute the pre-

existing data. A major advantage to using a qualitative approach is that the participants determine the themes rather than respond to the researcher's predetermined themes.

Due to the use of human participants and the sensitive subject matter, the Institutional Review Board (IRB) mandated that the study interview females 18 or older. Twenty-eight young women between the ages of 19 and 29 were interviewed. In order to assess the cultural underpinnings impacting sexuality development, I chose to include participants from multiple cultural backgrounds by interviewing 10 Euro-Americans, six African-Americans, six Latinas, and six American Indians residing in the Oklahoma City and Tulsa metropolitan areas. Although there was cultural, peer, and familial diversity in the population, all participants were upper working class to middle class and embraced middle class ideologies.

I had no difficulty in recruiting the participants. They were recruited by fliers posted in two busy clinics in the Oklahoma City area. Snowball sampling was also utilized. One participant posted the recruitment information on her Facebook page which resulted in many interested callers contacting me about participating.

After the participants expressed interest in the study, read the interview questions (Appendix B), and signed the consent forms (Appendix A), they were told about my background as a women's healthcare nurse practitioner and how their experience and ideas would be used to improve reproductive health care for younger females. The participants were eager to share their personal histories, and they also had advice for younger adolescent females based on positive and negative experiences.

The questionnaire was developed based on the literature review, and tested on five young women. Few modifications were made to the original questionnaire based on

the outcome of the sample questionnaire. Each interview was limited to 60 minutes based on the pre-arranged allotted time. All interviews were audio-taped and professionally transcribed.

In Chapter V, I present the "Findings and Conclusions" based on the 28 interviews. The chapter begins by outlining relevant demographic data. Eleven had children at the time of the interview but only 5 had had teen pregnancies. In response to the question, "Who raised you?" 12 of the participants were raised by both biological parents. Euro-Americans had the highest frequency of being raised by both biological parents, with the lowest frequency occurring in the Latino population. One participant, raised by both parents, had a teen pregnancy. Mothers alone raised 9 of the participants, with American Indians having the most (4), and African-American having the least (1). According to the literature, a strong mother-daughter relationship protects against risky sexual behavior (Aronowitz & Munzert, 2006; Doswell, et al., 2003; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Resnick, et al., 1997; Sieving, McNeely, & Blum, 2000). In this study, 19 reported that they did not have a strong relationship with their mother, while 9 said that they did. While strong mother-daughter relationships are important deterrents to risky sexual behavior, most did not experience such a relationship.

The importance of mother-daughter relationships is frequently cited in the literature, while contributions of extended family members are ignored. Other extended family members who were highly valued by my participants are as follows: aunts 18, uncles 12, and grandparents 14. These figures indicate that extended family members should be an important focus for future research.

As previously stated, the socioeconomic statuses of participants were upper working class to middle class. Further proof of middle class ideology is supported by the school attendance and performance reported by the participants. Twenty reported that they had good high school performance and 22 attended some college.

Information about sexuality and reproduction provided adolescent females with facts to help them determine how they wanted to participate in romantic relationships. In this study, I gathered data on their sources of information on reproduction. Fifteen cited the school system, 10 their mothers, and 5 their peers. The school system was the most frequently reported site for learning about reproduction. The disturbing factor about this statistic is that only one of the 15 participants reported receiving comprehensive sex education in school, while others only learned about menstruation and physiological facts about biology in their school programs.

Developmental theory suggests that risky sexual behavior occurs more frequently when romantic behavior begins in early adolescence, prior to the development of abstract thinking. Abstract thinking is needed for one to consider the consequences of one's behavior (Fonseca & Greydanus, 2007). There were a total of five teen pregnancies in the study population, with three occurring to participants who initiated intercourse between the ages of 14 and 15.

Adolescence is a time to develop independence and break family ties. Peer groups take on greater importance in adolescents' lives. Three-quarters of the participants were involved with same-sex peer groups, and more than half of all the participants described having mixed-sex peer groups. The literature states that in early adolescence, teens that identify with mixed-sex peer groups have less risky sexual

behavior than those who participate only in same sex groups (Cavanagh, 2007). American Indians were most likely to participate in mixed-sex peer groups and were also most likely to report having their first serious boyfriend later in adolescence. Considering all participants, 22 discussed romantic relationships with their peers. Although there was some missing data for "perception of sexual activity among peers," of those who responded, 16 thought their peers were sexually active.

Romantic activity is an important focus for adolescents. They frequently discuss romance with peers and construct their ideal romantic relationship within this group. Although peers play an important role, adult input is very valuable for guidance along this important developmental journey. In spite of the importance of adult direction, 11 of participants stated that there was no adult with whom they could discuss their romantic behavior. A surprising statistic was that only two participants discussed their romantic behavior with their sisters, and none discussed it with their brothers.

As stated earlier, all of the participants were able to give advice to younger females about how to improve their journey through their romantic development. After analysis of the responses, the messages were grouped in the categories: developing maturity before becoming sexually active, experiences to avoid and enjoy, making good relationship choices, and taking responsibility of the consequences of sexual behavior. Fourteen provided messages that emphasized a high level of maturity to develop your own maturation before beginning a sexual relationship. Nine of all participants gave advice about romantic situations that should be avoided. Most avoidance scripts described the pain of dissolving a romantic relationship that involved sexual activity. They acknowledged that the disappointment was so great because adolescent girls view

these relationships as culminating in marriage and living happily ever after. Ten of my interviewees suggested that adolescent females consider partner characteristics before becoming romantically involved. Others stated that if a romantic partner does not respect personal boundaries about sexual activity, then they are not good choices. In the final category of advice, 9 stressed that there are heavy responsibilities that results as a consequence of sexual activity. Most stressed the difficulties surrounding raising children, should one become pregnant, while others warned against the potential dangers of contracting an STD.

The data and analysis from my research buttresses much of the existing literature. The data were analyzed from individual and cultural perspectives. The importance of family, both nuclear and extended, was indicated. Although sex education is an important political topic, only one of the participants received comprehensive sex education in the school system. Same and mixed-sex peer groups were important in the participants' lives. Twenty-two of the participants could discuss romantic relationships with their peers, but 11 had no adult guidance about their romantic relationships. All participants were able to provide direction to younger adolescents. These messages from the participants should stimulate future research due to the participants' relatively recent experiences with adolescent romance.

In Chapter VI, "Conclusions," I summarize the major findings from my research and discuss the policy implications of the national, state, and local levels. While I hope to contribute to the literature on adolescent identity development theory, I would also like to make detailed recommendations to policymakers regarding halting funding for abstinence-only sex education and, instead, providing support for comprehensive sex

education programs. Professionally, healthcare providers and health educators can utilize new methods for delivery of sex education and healthcare delivery that include peer groups, nuclear family, and extended family. This combined effort is needed to better inform our adolescent females about sexuality, in order to reduce the number of unwanted pregnancies, STDs, and the emotional pain that accompanies poor decisions.

# CHAPTER II – REVIEW OF THE LITERATURE

Understanding the lives of adolescents can be frustrating and daunting. Throughout the ages, adults have repeatedly shaken their heads wondering how teenagers survive in the adolescent world. It is a unique world that differs greatly from generation to generation. As a result, parents frequently bemoan the style of clothing, the colors of hair, the rampant sexuality, and the degradation of American media influencing their developing adults.

Technology, mass media, and the information age have significantly changed the information adolescents receive today as compared to a century ago. Despite these changing messages, societies, families, and friends have remained major influences for adolescents. The complexity of life to the average adolescent proves to be challenging. They experience physical changes, social growth, and increased educational demands while trying to develop an independent identity. Despite several theories about general adolescent development, there is limited data about how adolescents make decisions about their sexuality. Sexuality is an important drive in human beings. It is the way we experience and express ourselves as individuals, in relationships, and in society. Unlike many animals, humans are not only sexually active for reproduction but also for a variety of other reasons (Molina, 1999). As children develop into adolescents, they begin experiencing a new awareness of how their sexuality influences their world. This dissertation attempts to assess how adolescents make decisions about romantic relationships to better understand how they make decisions about their sexuality.

## Adolescent Development Theories

As a healthcare provider, part of my time is spent teaching and describing child and adolescent development to parents and helping them better understand the stages their children are passing through. It seems as though parents have a journey through time, always anticipating and preparing for the next stage of parenting. When children are infants, parents wait for them to become toddlers. After the terrible twos and trying threes, parents anxiously await the beginning of school and the first day of kindergarten. Parents then watch their children transition into middle school, which is often referred to as the beginning of the true challenge of parenthood. An unknown author described the journey from the perspective of the parent as, "Adolescence is a period of rapid changes. Between the ages of 12 and 17, for example, a parent ages as much as 20 years." The struggles experienced by the parents result from the physical and cognitive growth of the child in areas such as sexual awareness and development. Scholars from multiple fields have analyzed the developmental changes in adolescents from the physiological to psychological perspectives, which will be discussed in terms of major adolescent development theories.

Adolescence, typically ages 11 to 25, is a time to develop one's personal identity, which includes a sense of sexual self (Fonseca & Greydanus, 2007; McMillan, 2006; Smith, 1993). While developing identity, adolescents are also experiencing changes in cognitive development which affect abstract thinking and the ability to assess consequences of one's behavior, including sexual behavior. Adolescent psycho-social development that encompasses developing identity and cognition is divided into

three periods: early adolescence (11-14 years), middle adolescence (15-17 years), and late adolescence (18-25 years) (Fonseca & Greydanus, 2007).

The separate periods of adolescence are marked by differing levels of abstract thinking which impact behavioral decisions. Early adolescents lack the ability to think abstractly and are only able to consider immediate reactions to behavior. They are not able to appreciate long-term consequences of their behavior. Middle adolescents can participate in abstract thinking, connect separate events, and understand later behavioral consequences. Late adolescents are able to think abstractly, philosophize, and consider social problems, conditions needed to make thoughtful decisions (Fonseca & Greydanus, 2007).

If initiation of sexual activity in adolescence precedes the development of abstract thinking (middle to late adolescent stages), there is a greater risk for unwanted sexual outcomes (McMillan, 2006). The standard cultural belief that early sexual activity in adolescence is filled with risks and difficulties matches the scientific belief that young adolescents lack the cognitive abilities to fully understand the outcomes of their actions. Despite the potential cognitive limitations, the majority of teenagers make the complex transition from adolescence into adulthood without significant difficulty (McMillan, 2006). It is this disparity between theory and reality that requires more research. This study will assess whether age of initiation of romantic relationships can predict the behavior within the relationships. It will be assessed within the theoretical constructs of adolescent cognitive development in relation to culture, sex education, peers, and family.

Adolescence is a time to explore sexuality. They indicate that adolescents across the globe partake in sexual activities at similar levels among developing countries. The United States' (US) statistics for initial sexual activity and sexual behavior did not differ significantly when compared to other developed countries, but teen pregnancies and STDs are more prevalent in the US. When highlighting cultural differences between the countries, the ones (Great Britain, Canada, Japan and Netherlands) with lower rates of teen pregnancy and STDs typically have a greater cultural acceptance of expressions of adolescent sexuality. They combine this with comprehensive sex education, expectations of developing relationships, and encouragement to use protection to prevent teen pregnancy and STDs (Feldmann & Middleman, 2002). While these strategies can potentially reduce the incidence of risky sexual behavior, they provide only limited insight about what influences adolescents in their journey of developing sexuality and in their sexual decision-making. For this study, decision-making will include the ability to think abstractly, reason, and consider individual and social consequences to problems.

*Adolescent Development and US Cultural Underpinnings*

Several researchers have analyzed US cultural underpinnings in regard to the developing females' sexual identity. As a result, conceptual frameworks exist that link female adolescent development of sexual identity and romantic behaviors. They address how adolescent females internalize issues, including power imbalances in relationships, denial of sexual feelings, and virginity loss. Understanding how the females view themselves in these complex theoretical constructs aids in evaluating their developing sexuality.

*The Effects of Power Imbalances in Romantic Relationships.* The first factor examined for its effect on adolescent romantic behavior is power imbalances in relationships. According to some research, power imbalances (unequal influence) exist in adolescent romantic relationships which impact females, not only in their immediate relationships, but also in their long-term sexual development (Fine, 1988; Fine & McClelland, 2006; Tolman, 2002). Gilligan's (1982) classic work, "In a Different Voice," describes divergences between men and women in regard to cognitive development and how each gender makes decisions. In a patriarchal society, male cognitive development requires a separation from females in order to develop manhood. This separation from females is not a problem unless the concept of male is considered better than female. In that case, the adolescent female ends up striving for separation from other females. This creates a disassociation resulting in an inner division, or a psychic split, that is, as a consequence, self-devaluing. It is this concept of devaluing females that underpins a power imbalance in romantic relationships. In an effort to maintain romantic relationships, adolescent females who support the concept of patriarchy silence their voices in heterosexual romantic relationships. Hence, they lose relational power as they move through adolescence into womanhood.

In addition to Gilligan's cultural perspective, a study by Taylor, Gilligan, and Sullivan (1995) examined why power imbalances exist from individual perspectives. The study explored the relationships of 26 adolescent females from multicultural backgrounds. The adolescents' perceptions of imbalances of power in their relationships were the basis for a common, major developmental challenge. The challenge that they struggled with was whether to give up their own voices and perspectives in order to stay

in a romantic relationship. The ones who were most successful in maintaining their voices and acquiring independence did so as a result of a strong relationship with a mother and/or another adult woman who encouraged their individual development. The girls who succumbed to giving up their voice gave up their power and sense of self. They no longer expected to have their own interests or needs met in a romantic relationship. Taylor et al.'s work indicates that adolescent girls are experiencing growth in two areas: the desire to be involved in romantic relationships and the desire to find one's own self.

While Gilligan's (1982) and Taylor et al.'s (1995) work provide a glimpse into the struggles between voice and power, they are limited in that they place all females in the category of subjugation and passivity. This is a recurring problem in similar research, with some scholars committing additional errors. For example, minority adolescents who are not subjugated and passive are often presented as immoral and irresponsible. This is in contrast to Euro-American girls and women who are frequently placed in a position of virginal virtuosity (Bay-Cheng & Lewis, 2006). A study by Morrison-Beedy Carey, Cote-Arsentault, and Seibold-Simpson (2008) disputes the myth of immorality and irresponsibility of minority adolescents with the example of a group of African-American urban girls who display characteristics of self-respect and self-worth. These characteristics supported their choices to delay the onset of first intercourse and use of protection when participating in sexual relationships. They displayed little evidence of subjugation or passivity while being accountable for their romantic and sexual experiences with responsible behavior. Collectively grouping all females into the categories of "submissive" and "passive" dismisses the individual

cultural differences among women. Despite these limitations, the studies still indicate the existence of a tension between having a voice in a relationship and desiring to be in a relationship.

The developmental stages of discovering individual differences between self and others and building relationships are both important tasks contributing to the development of sexual identity (Fonseca & Greydanus, 2007). This development of the sexual self in adolescents greatly impacts one's capacity to enter into romantic relationships (Fonseca & Greydanus, 2007; McMillan, 2006; Smith, 1993) and supports the transformation from adolescence into adulthood (Connolly, Craig, Goldberg, & Pepler, 2004; Pedlow & Carey, 2004). In other words, developing romantic relationships in adolescence builds the foundation for adult romantic relationships (Smith, 1993). There is very little research that addresses this transition. It is important to understand how adolescent females balance power in their adolescent relationships in anticipation of developing adult relationships. This comparison will better inform researchers about whether females improve their decision-making within relationships as they age and/or have more experience with romantic relationships.

There is a gap in the literature in identifying the factors that motivate women to have sex and the conditions that shape their willingness to take risks (Higgins & Hirsch, 2008). For example, research shows that adolescent females who participate in sexual activity without the use of condoms or engage in anal intercourse, which increase the risk of contracting an STD, reported that they lacked power in their romantic relationships (Donaldson-James, 2008; Lescano, Brown, Miller, & Puster, 2007; Lifespan, 2008). While one's perception of power influences decision-making, it is

unclear how the power issue translates into adult relationships. Understanding adolescent females' motivations for romantic relationships will address this gap in the literature.

*The Effects of the Denial of Sexual Feelings.* The second factor examined in regard to adolescent romantic behavior is the psychological effect of the denial of sexual feelings in young females. Tolman's (1991, 2002) research examined adolescent development of self as a sexual being for males and females. She concludes that American males are allowed to act upon their natural sexual desires due to a perceived right to sexual activity. In contrast, females' sexual desires are denied, and their sexual activity is only a response to male desire (Tolman, 2002). Females are taught that males have innate sexual desires prompting their sexual activities while females' sexual activity only occurs as a result of males' sexual initiation.

Additionally, females are often depicted as victims of pregnancy and STDs with the rare consideration or mention of their own sexual desires. The lack of recognition and denial of sexual desires in females creates a disconnect from their own bodily experiences, especially when developing romantic relationships with accompanying sexual activity. A dilemma resulting from this disconnect can affect all dimensions of desire by limiting one's ability to know oneself and know what one wants (Debold & Malavé, 1993).

Studies suggest that denial of sexual feelings in the adolescent female is correlated to risky sexual behavior (Taylor, et al., 1995; Tolman, 2002). This study will explore the participants' awareness, sense of need, or appreciation of sexual desires as factors contributing to their adolescent and adult relationships. Understanding this may

provide important insight into another dimension of the impact of power in relationships. If females deny desire, which is the source of expectation of sexual fulfillment and pleasure, then the sexual activity may be occurring as a result of power imbalances. Lack of entitlement or empowerment in one's own sexuality leads to a spontaneous sexual experience, often described as "it just happened" (Tolman, 2002). When sex "just happens," there is no time to decide if the experience is in one's best interest or could result in unplanned pregnancy and/or STDs.

*The Effects the Loss of Virginity in Young Females.* A third factor important to the development of adolescent romantic behavior is the significance placed on losing one's virginity. Carpenter (2005) explored the loss of virginity (the first time a person engages in vaginal intercourse) considering individual and gender perspectives. She identified three main themes which metaphorically describe loss of virginity as a gift, a stigma, or a developmental process. These themes predict how the individual will feel about their status and how it relates to power in their romantic relationships.

Only women who interpreted their lost virginity as a gift consistently felt disempowered in the relationship. Women who viewed their virginity loss as a stigma felt empowered in relationships. Those who viewed their virginity loss as a developmental process were less likely to frame the experience as negative or as loss of self-control (Carpenter, 2005). The perspective taken regarding one's lost virginity, either positive or negative, is associated with the perception of power in the romantic relationship.

The loss of virginity acts as more than a simple step toward womanhood. Instead, it is an important developmental step for adolescent females since it connects

the loss of virginity to the concept of self. This colors their sexual identity in future romantic endeavors as adolescents and adults. While Carpenter effectively showed how power and virginity loss are connected, she did not address how these two factors influence decision-making about sexual activity. The term virginity loss has negative connotations. This study will examine whether a female's perception of her first intercourse experience is positive or negative and how it impacts her sexual choices as related to risky behaviors.

If scholars can predict how initiation of first intercourse either empowers or disempowers adolescent females and influences their sexual health, then messages can be tailored to better prepare them to make less risky sexual decisions. In Chapter V, under the heading, "What Advice Would You Give Your Sister," participants reflect on their virginity loss experiences. The motivating factors contributing to their sexual debut can be construed from this data.

Adolescence is a time to explore personal identity and determine how it relates to the development of one's sexual self. Contributing factors include power issues in romantic relationships, how to recognize sexual desires, and how to internalize intiation of first intercourse. These issues simultaneously influence sexuality as young females attempt to define their roles in romantic relationships. The roles adolescent females play in romantic relationships influence their decisions about sexual activity and about how to protect their personal health and well-being. As stated previously, American adolescent females make poorer choices in protecting their sexual health than females of similar countries worldwide, despite similar rates of sexual activity. The emotional, physical, and economic hardships caused by adolescent pregnancies and STDs demand

the re-examination of these and other influences on adolescent sexual behavior. We need to determine what factors contribute to this increased rate of risky sexual behaviors in order to reduce them.

## Culture

Watching the evening news often provides a skewed glimpse into American culture. The majority of the news focuses on the social pathology in everyday life. Many of the segments over-represent minority involvement in crime or focus on mostly negative activities within a community. Academic research about adolescent sexuality follows the same pattern as the evening news. The research explores the risks and consequences of adolescent sexual behavior. The pathology of the behavior is emphasized while ignoring or omitting the positive stories. An additional limitation of current research about adolescent sexuality is the limited attention to the cultural context in which the behavior occurs.

For years, anthropologists have emphasized the study of culture as a context for interpreting the world around us. Due to its intense complexity and fluidity, however, researchers have struggled to include it as a key factor in data analysis. Culture, defined by Philipsen (1992), is “a socially constructed and historically transmitted pattern of symbols, meanings, premises, and rules” (p. 7). Hence, culture is a code of behavior which people learn over time from the people with whom they interact on both the group and societal levels. An adolescent’s sexual identity is socially constructed within her culture. For the purpose of this study, the most relevant sub-topics of culture related to adolescent sexuality will be examined including gender, socioeconomic status, and race.

*Gender*

The differences between men and women have been written, sung, acted, and conversed about in every aspect of the American culture. Unfortunately, in all of these popular cultural depictions of the differences between men and women, the terms sex and gender are used interchangeably, suggesting that they are the same concept. However, in the medical and social science communities, sex and gender have very different meanings and connotations. Sex is defined as the biological characteristics differentiating males and females. Alternately, gender is defined as the behavior assigned to males and females within a social context that is demonstrated in the interactions with others (Basow, 2006). For example, a man may have female gender characteristics while a woman may have male gender characteristics. The sex of a person is relevant to his/her sexual identity, but gender provides more insight into how sexual identity develops and how decisions are made within that identity.

The concept of gender is a learned behavioral characteristic as opposed to being an innate physical trait. In behavioral theory, the social cognitive theory of gender development and differentiation suggests that humans learn about gender roles in three ways: 1) by modeling the behavior of people they admire and want to emulate, 2) by experiencing the consequences that follow their gender-linked behavior, and 3) by watching social reactions to their behavior (Bussey & Bandura, 1999). Since gender is learned from the people with whom they interact, male and female gender roles usually fall into culturally-specific categories.

In the United States, the gender roles women and men emulate do not necessarily complement each other in sustaining the growth and evolution needed to build healthy relationships. Women's gender traits usually include expressiveness, nurturing, and a relationship orientation. Men's gender traits usually include high levels of activity and autonomy. Additionally, men tend to be less relational, more independent, and more decisive than women (Abrams, 2003). These male traits have been historically, and are currently, more highly valued in our society and carry greater power in relationships. The nature of the masculine characteristics creates imbalances within relationships since males focus on independence. This independence leads to individual decisions which create serious imbalances in relationships (Abrams, 2003; Kornreich, Hearn, Rodriguez, & O'Sullivan, 2003).

Both sexes learn about gender roles from the beginning of life. Gender construction is not static since it continues to be developed and redefined as we mature and grow (Basow, 2006; Ruble, et al., 2007). It is often expressed in the different way girls and boys dress, body language, and behavior. Young girls experience more flexibility than boys in their conceptualization of gender identity; specifically, girls have a wider range of acceptable gender behavior. In terms of dress, girls may wear traditional boys clothes, such as pants and baseball caps, but boys are not encouraged to wear skirts or dresses. Girls may play with fire trucks, action figures, and military toys, while boys are discouraged from playing with cooking appliances, dolls, and hair products (Ruble, et al., 2007). These distinctions between acceptable and unacceptable behaviors are taught at home, at school, in public, and within the social groups of the children (Basow, 2006).

The social groups within which children play tend to be same-sex groups between the ages of seven and pre-puberty (Cavanagh, 2007). If a boy or girl attempts to cross the gender lines and co-exist within both genders, he/she may experience disapproval from both groups. It is during this age range that gender behaviors get reinforced which lead girls and boys to make decisions about their future sexual expression. For example, as girls approach puberty, they become more interested in attracting a mate. They tend to be less career-oriented and less interested in a traditionally male curriculum that includes math, science, and computer courses.

It is logical that a clear gender identity, one which follows the strict lines of male or female, would greatly benefit an individual since it would facilitate compulsory heterosexism. However, evidence suggests that people who possess both masculine and feminine gender traits have more success (better mental health and self-esteem) in their careers and personal life (Basow, 2006). While this evidence is informative, additional information is needed to determine if adolescent females who practice both gender traits – specifically, an independent nature – make different decisions about romantic relationships than those who have primarily female gender traits.

The development of gender identity occurs as a result of the culture in which one lives. It is a multifaceted concept that develops over a lifetime. Gender significantly influences how females and males interpret the world around them and how they understand the power structures in their own societies. If females who possess both sets of gender traits make healthier decisions in romantic relationships, then I might assert that power is more equal in those relationships. The complexity and intricacy of gender, especially as it relates to power in romantic relationships, is critical to the understanding

of romantic behavior in adolescents, and this will be explored further. Additionally, socioeconomic status is a complex, cultural factor influencing adolescent's sexual development and sexual identity.

*Socioeconomic Status*

Despite the fundamental correlation of health to one's socioeconomic status, it is a relatively elusive research measurement. Socioeconomic status (SES) is a composite measure made up of income, educational level, and occupation (Saegert, et al., 2006). All of these factors are relatively complex and difficult to measure independently. Therefore, grouping them together to describe socioeconomic status presents numerous challenges. However, the need to analyze its impact is great, since the US's disparity of wealth contributes to social problems resulting from low socioeconomic status (Cacioppo, 2002). Although the US has considerable wealth compared to many nations, the inequality of wealth between the social classes has increased since 1981 and continues to widen. This inequality is correlated with increased levels of social discontent across social classes. There is a political underinvestment in health care, public education, and social programs. The social side-effects of this underinvestment includes a decline in public health and rising crime rates due to high-risk behaviors including smoking, drinking, risky sexual activities, and drug use (Saegert, et al., 2006).

The social environment in which one lives impacts one's physical and emotional health. More specifically, adolescents are shaped by the socioeconomic groups. Childhood social experiences and environments can either positively or negatively affect adolescent growth and identity development (Call, et al., 2002). Hence, the

socioeconomic status in which one is raised has significant influence on adolescent sexual development.

When reviewing the literature linking adolescent development and romantic relationships, it is important to consider the SES. A major error made by the media and in research is the misrepresentation of race factor in deviant behavior without considering socioeconomic status. In other words, race is often correlated with a person's behavior instead of socioeconomic status. This misuse of race, especially when referring to minority groups, can lead to stereotypes and distortions being assigned to that special group within a pathological framework (Wyche, 1993). SES is a better social indicator of behavior than race (Saegert, et al., 2006). This study will examine the relationship between social class, race, and a variety of social experiences, thus exploring indirect influences on decision-making skills in adolescent females.

*Income.* Currently the US is in an economic crisis that could be the worst recession since WWII. Unemployment is on the rise with economists predicting the peak to occur sometime in 2010 (Kaiser, 2009). Whether one is optimistic or pessimistic about the stimulus package, the current crisis is affecting most citizens because their income is being reduced. Adequate income provides one with a feeling of security, and this security often comes from one's potential power to acquire food, clothing, shelter, and health care. Income is generally acquired through received assets from labor, services, sales, or gifts. It provides a means to acquire material goods and services such as education and health care. Historically, one-third of the US population will suffer an unexpected drop in income of more than 50% during an 11-year period which drastically impacts a family's emotional and physical security (Saegert, et al.,

2006). It is expected that our current economic crisis will have a more negative impact than these historical predictions. Of great concern, due to the economic downturn, is the issue of health care. Although there is a universal healthcare component in the new budget (Crutsinger, 2009, February 26), health care access for low-income individuals is a concern in the meantime.

Several studies have correlated income and poverty to adolescent risk behaviors. These studies used large, national databases consisting of populations greater than 10,000 youth between the ages of 12 and 21. Blum, Beuhring, Shew, Bearinger, Sieving & Resnick (2000) found less than 10% variance in all the adolescent risk behaviors, and Santelli, Lowry, Brener, & Robin (2002) found that household income was not correlated to risky sexual behaviors. A potential reason these studies found little to no correlation is that they failed to look at the bigger picture of wealth and security as related to income. In other words, the studies failed to assess the presence or absence of security in the lives of the adolescents as a result of income. This limitation is due, in part, to the nature of quantitative studies. Qualitative studies, such as this one, are needed to examine the complexity of income to either support or refute its significance with regard to risky sexual behavior in adolescents.

This dissertation focuses on adolescents who are unlikely to have an income. Therefore, the income of the participants' parents provides the most insight into the various social contexts, health programs, and educational systems available to the adolescents. Many children do not know the income of their families, but they do have a general sense of the financial security of their family. The family income level will

influence the type of school and extracurricular activities available to the adolescent female. The influence of these activities on romantic decision-making will be examined.

*Occupation.* Employment or work usually provides a financial reward. The contribution it makes to one's SES is extremely difficult to measure due to the varying benefits and risks that accompany a job. Some of the benefits and risks of employment include the prestige and status associated with the occupation, health risks due to the job, and job stress. For example, an employee's physical health might be impacted by factors such as access to quality health care, physically hazardous working conditions, or physically straining shift work. Additionally, mental health on the job is affected by the status attached to the work, social networks created, and meaningfulness of the work accomplished (Saegert, et al., 2006).

Since occupation affects the quality of life of the worker, it is logical that the benefits or drawbacks of the employment impact family life. The participant's stories will be scrutinized for family stress resulting from parental occupational pressures. For example, the stresses of physical labor and restricted medical care to a parent would also cause stress on the child. However, no current literature directly and fully establishes how the occupation of the parents impacts the development of adolescent identity. This absence of data encourages its examination in this study.

*Educational Level.* Through the progression of generations, the importance of education has changed within American culture. While at one time in our history, many high school seniors found jobs upon graduating, they now remain in a somewhat dependent role as they head for their first year of college. Whereas completing high school was once considered enough education, now many parents expect the children to

complete a college education. Generally, higher levels of education are associated with greater economic outcomes, increased social and psychological resources, and fewer risky health behaviors. Education equips individuals with improved cognitive skills and more general knowledge, to assist them in achieving better life outcomes (Saegert, et al., 2006) such as higher paying jobs, stable families, and more leisure time.

Despite the societal pressure to complete college, many parents would be pleased if their child completed high school. High school students from low-income homes are six times more likely to drop out of high school than their peers from high income homes (Horn, 2006). Another major factor influencing the completion of high school for females is teen pregnancy. It is estimated that 40% of teenagers who give birth at the age of 17 or younger do not finish high school compared to 25% of teenagers who gave birth at the age of 20-21. Teen pregnancy also influences whether one completes college. The attainment of two years of college is significantly affected by teen pregnancy. When the first birth occurs at 17 or younger, 5% of those teens obtain two or more years of college by their late twenties compared to 21% who had their first child after the age of 20-21 years of age (Hoffman, 2006). Regardless of the age of first birth, the educational level completed by the adolescent impacts the overall quality of life for her family.

Unfortunately, gaining access to education remains difficult despite its prevalence. College entrance is filled with inequities (Walpole, 2008). A study by Rowan-Kenyon (2007) examined factors which supported or impeded entrance into college. College eligible high school students, who had low socioeconomic status, less math course work, parental involvement, peer encouragement, and the mother's

expectation of college achievement, delayed their college enrollment by one to two years. After controlling for other variables including race, SES had the greatest impact on college enrollment.

College entrance does not eliminate the obstacles for students with a low SES. A study by the National Center for Educational Statistics (Horn, 2006) shows that the graduation rates of low-income students are low. Additionally, even nine years after entering college, low SES students continue to report lower rates of degree attainment, lower incomes, and lower likelihoods to attend graduate school than students of higher SES status (Walpole, 2008).

There is a group of people who are somewhat protected from low levels of American education. Many first-generation immigrants raise their standard of living beyond the average American of similar educational attainment. First-generation immigrants with third or fourth grade educations have higher self-perceived social status than Americans in similar conditions. They perceive their standard of living in the US as considerably higher than in their country of origin. They maintain this perceived higher status by sharing assets in a communal-like setting (Rosenberg, Raggio, & Chiasson, 2005). Therefore, their education level and perceived SES may not have the same negative influence as lower SES for minorities who are not first generation.

The positive influence of education has been proven time and time again by research programs across the country. It is this country's basic premise that primary and secondary education should be available to all citizens, but not all students have equal preparation or support to attain it. Under the guise of this premise, former-President George W. Bush's education initiative, No Child Left Behind (NCLB), was hailed as a

bipartisan victory for underserved public schools. However, the law did not address the inequities that plague the school systems in the US. The NCLB aimed to raise student achievement by setting annual test score targets for sub-groups of students. Critics of NCLB claim that the testing has dumbed down the curriculum and changed the focus of education, resulting in teaching solely to the tests (Darling-Hammond, 2007). Math and English received an increase in attention in the majority of elementary schools, while time was cut on social studies, science, physical education, art, and music (McMurrer, 2007). There are no courses in the curriculum addressing life skills or comprehensive sex education with little chance for inclusion as the focus on math and English are needed to raise the overall test scores. When schools with low test scores are labeled as failing, it is hard to retain or attract good teachers, placing the school at greater disadvantage. It is also believed that some students are retained at a grade level to improve test scores, which ultimately causes students to do less well and drop out at higher rates. NCLB has added to the current economic inequities in a national school system where the high-spending schools outspend low-spending schools by 3 to 1. A substantial paradigm shift is needed in the school system to change the focus from merely testing, to making our schools powerful places of learning for all students (Darling-Hammond, 2007).

To an adolescent, the importance of education extends beyond the classroom curriculum. It teaches additional valuable lessons through social networks and extracurricular activities which contribute to better social skills and overall confidence. It is this multi-faceted outcome of education which is a focus of this study. Educational issues, which will be explored in this study, include extracurricular activities and sex

education classes and their impact on romantic relationships. Additionally, links between educational attainment and teen pregnancy will be explored.

The combined influence of income, occupation, and education defines each person's and family's socioeconomic status. High levels of SES correlate with good health which is one of the reasons scholars measure SES. There have been recent suggestions that intelligence levels are key factors influencing people with good health since high levels of intelligence drive one's ability to access income and obtain education. However, in a study exploring a person's intelligence level while holding income and education constant, intelligence had little effect on the status of one's health (Link, Phelan, Miech, & Westin, 2008). The results of the study support the traditional belief that it is SES, and not intelligence, which has the greater impact on health. Unfortunately, few studies have included SES statistics, as defined in this paper, in data collection on adolescent behavior. SES of the participants and their caregivers plays a major role in influencing behavior, suggesting that it is an important concept to consider when exploring adolescent female romantic behavior.

*Race*

As mentioned previously, scholars do not always distinguish between race, ethnicity, and socioeconomic status when conducting studies analyzing the impact of culture on behavior. According to the American Association of Physical Anthropology (1996), race, which is based on popular concepts from the 19$^{th}$ and early 20$^{th}$ centuries, is considered the biological, externally visible characteristics of skin color, the skeletal system, and facial size, shape, and features. It was thought that these physical characteristics defined an individual or a population. Race is not a good indicator of

culture due to its lack of descriptive properties, but current literature often reports findings based on race. Ethnicity, however, includes the socioeconomic context that defines culture (Hernandez, 1997). Racial identity is used in this study to identify groups, but ethnicity and culture within and across groups will be explored for their impact on adolescent decision-making since they are the primary source of data.

I began my research among American Indian students but later decided to expand it to include Euro-Americans, African-Americans, and Latinas, representing all federally-recognized racial groups, except Asians. However, I did not seek to interview them, both students and non-students, in proportion to their racial group's proportion of Oklahoma's population. In the course of the interview, I gave each interviewee the opportunity to self-identify.

*Euro-Americans.* A majority of the literature about adolescent development is based on studies of Euro-Americans. Even though many of these studies make developmental claims, they often fail to assess the varying cultural elements impacting Euro-American female adolescents. The dominant culture is not analyzed for its cultural influences and is frequently the standard of comparison for all groups.

One particular byproduct of the American culture is the sexualization of female adolescents and women. A primary social identity for Euro-American girls is their gender, which results in a stronger gender bias in white girls than in girls of color (Leaper & Brown, 2008; Turner & Brown, 2007). Young females who most strongly identify with gender biases are more susceptible to sexualization. Sexualization is defined as a female only being valued for her sex appeal from conditions such as her physical attraction relating to sexuality, sexual objectification defining personal value,

and sexuality being inappropriately imposed upon her. In each of these conditions, female adolescents are more likely to be objectified and sexualized than males. Cultural sexualization is present in television, music (videos and lyrics), movies, magazines, newspapers, sports media, computer games, internet, advertising, products, clothing, and the use of cosmetics. In a study assessing the outcome of sexualization, scholars have correlated it to a variety of harmful consequences such as impaired cognitive performance, body dissatisfaction, eating disorders, low self-esteem, and physical health problems (Zurbriggen, et al., 2007).

A cultural practice directly related to sexualization is elective plastic surgery. The number of minors receiving plastic surgery is an alarming statistic. Teens, 19 years of age and younger, received 87,601 surgeries in 2007. This number represents a 14% increase from 2006, and in 2005, there was a 15% increase from the previous year (American Society of Plastic Surgeons, 2007b). The majority of the adolescents under the age of 18 choosing these surgeries need parental consent and, frequently, the parents finance the surgery. The majority of the patients are Euro-American, although the number of minority recipients is growing (American Society of Plastic Surgeons, 2007a). This statistic on elective plastic surgery suggests that teens suffer from high levels of body dissatisfaction. It also suggests that their parents support this dissatisfaction financially with a willingness to accept the risks involved with unnecessary surgery. What the research does not tell us is how this feeling of body dissatisfaction affects decision-making in romantic relationships.

In contrast, Abrams (2003) observes that Euro-American adolescent females resist norms of femininity that have negative outcomes. In a state of rebellion, Euro-

American adolescent females adopt masculine forms of behavior that result in a higher incidence of substance abuse, truancy, and aggression. The study does not identify other cultural conditions that contribute to identification with maladaptive male behavior.

The problems that result from sexualization and strong gender bias are difficult to place in categories based on racial identification. All components of culture influence the ability of adolescent females to make decisions about their gender identification and their role in developing romantic relationships. In the next section, I will discuss the identities of women of color who provide some resistance to negative dominant culture norms.

*Adolescents of Color.* Although African-Americans and Latinos are classified as members of different races, much of the research lumps these adolescents together and makes sweeping generalizations about cultural impacts on the two groups. Abrams (2003) observed that there is little analysis of operationalized gendered stereotypes in different cultures. For example, Basow (2006) reported that African-Americans and Latinos resist female passivity and body dissatisfaction, but did not discuss how the two cultures differ in accomplishing this.

In another study assessing adolescents of color, it was found that females with strong ethnic identities have developed a sense of self which may provide some protection against an idealized concept of women as lacking assertion and independence. These females also have resisted media depictions of the ultra thin woman, which seems to give them protection against eating disorders. This study, however, did not indicate how gendered stereotypes are operationalized in African-

American and Latina cultures. However, it does show that ethnic identity may provide protection against high risk behaviors (Abrams, 2003).

In another example, Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, and New (2006) found that African-American and Latina inner-city females experienced pressure from other females to experiment sexually in order to gain social status from involvement with males. These social pressures have implications for sexual behaviors and sexual outcomes such as STDs and unwanted pregnancies. In yet another study of urban females' sexual behaviors, O'Sullivan and Hearn (2008) assessed the sexual cognitions of early adolescent females' perceptions of first intercourse in African-Americans and Latinos. Before first intercourse, the females reported that they anticipated painful emotions and social unpopularity. Afterwards, they reported feeling bad, nervous, and disgusted. However, when interviewed at a later date, they recalled their last intercourse event primarily through positive emotions, including happiness, attractiveness, and confidence. This study brought to light the problems that can result from the warnings given about first intercourse and the actual experiences with intercourse for these urban females. The findings suggest that authorities who teach the doomsday predictions about first intercourse and rarely describe female adolescent sexuality in positive terms may lose credibility with adolescence.

While both of these studies provide relevant and informative conclusions, neither study differentiates between the two cultures. Their research shows that the girls have the same sexual outcomes while not identifying factors influencing the decisions in each case. By knowing how the girls reach the same conclusions, practitioners can better tailor messages to each group of girls in order to best communicate information

regarding healthy decision-making in romantic relationships. Through the cultural analysis already discussed, this dissertation will attempt to address the limitation of lumping multiple cultures/races into the group of adolescents of color. The next three sections identify differences between the three groups of color involved in this study: African-Americans, Latinas, and American Indians.

*African-Americans.* The Civil Rights Movement of the 1950s and 1960s made great advances in obtaining equal rights for African-Americans. While this political advancement asserted that the African-Americans and Euro-Americans theoretically had equal rights, the two groups of people had different sub-cultures which influenced their lives greatly. In today's America, the different races may have varying approaches to some aspects of daily life including sexuality and adolescent involvement in romantic relationships.

African-Americans are more resistant to the dominant cultural norms of sexual expression and romantic ideals. Specifically, they have more resistance to the dominant culture's sexual norms for females. They reject the perfect body image presented by the media and the image of the passive, demure, soft-spoken woman. These rejections are necessary to combat the social inequities experienced from their minority status (Archer, Halsall, & Hollingworth, 2007).

African-American females experience significant cultural pressure regarding romantic relationships. In a study by Martyn and Hutchinson (2001), a group of African-American females at high risk for poverty and early childbearing were interviewed to determine how and why they avoided pregnancy through their adolescence. The retrospective interviews concluded that low-income African-

American females receive social and cultural messages encouraging lives of poverty, dependence, and early childbearing. The subjects metaphorically rewrote these negative social-psychological scripts, obtained from the people around them, by changing their behavior to avoid early pregnancy and lives of poverty. According to this study, the females rewrote these scripts in an effort to improve their personal futures and life outcomes.

Another study of predominately African-American adolescents by Morrison-Beedy et al. (2008) addressed the impact of self-worth on sexual activities. The target population was adolescent females who were abstinent, and it explored behaviors which supported abstinence. They found four themes which influenced the adolescents' decisions to remain abstinent: 1) they felt strongly about their own self worth; 2) they had mothers who supported their choice to be abstinent; 3) they believed that males were not sexually responsible and that females could resist pressure to have sex; and 4) they reported the potential negative consequences that would result from sexual activity. The study showed the African-American adolescents remained abstinent by choice due to their feelings of self-worth even though the messages about males and intercourse were negative.

While the studies discussed have provided important data about the sexual activities of African-American females, they all share a significant limitation. The studies all assume that all African-American females behave in the same way by ignoring differences in socioeconomic levels. This assumption places too much weight on the classification of race while ignoring other cultural factors such as gender roles

and socioeconomic status. This study will attempt to determine if these and other factors influence African-American females' romantic decisions more than race.

*Latinas.* According to Smokowski and Bacallao (2006), Latinos are the fastest growing minority group in the nation. Forty percent of the Latino population is foreign-born and slightly over half of that population arrived in the US after 1990, indicating that adolescent Latinos are experiencing drastic cultural changes. Despite the extreme changes in lifestyle and culture, very little research has examined the effects on Latino adolescents' sexual development. Traditional Latino culture places great emphasis on family and relationships. Motherhood is an important source of identity for Latinas (Brabeck, 2006).

A study by Bazargan and West (2006) explored factors associated with sexual activity in a population of Latina girls. Their sexual activity was subject to peer pressure, lack of fear of pregnancy, and lack of skill to refuse sexual initiation. In another ground-breaking study, Villaruel, Jemmott, Jemmott, and Ronis (2006) identified ways to reduce risky sexual behavior in Latino adolescents. In the context of the study, it was found that risky sexual behavior could be addressed by an HIV prevention program. By using a behavioral theory, culturally sensitive material, and other interventions, inner-city Latino adolescents reduced their risky sexual behavior through this prevention program.

While there is some research about Latina females' sexual activities, the general body of knowledge of the topic is incomplete. This study will add to this body by assessing adolescent Latinas' behavior in romantic relationships. Latinas will be

examined as their own cultural group instead of being lumped together with African-Americans or other adolescents of color.

*American Indians.* While the problems surrounding studies of other races are profound, there are even more concerns about the lack of available research on American Indians. More specifically, hardly any research exists about American Indian adolescent sexuality, due in part, to the tumultuous past of the American Indians. Although a detailed history of American Indians will not be discussed here, it is important to understand that there have been US government policies and practices that appear plausibly genocidal to many American Indians. Many of these policies and practices were implemented as recently as the 1960s and 1970s. Many of the policies involved women's health issues such as non-consensual sterilization and abduction of Indian children (Christopher, 2005; Udel, 2001).

Due to past unethical practices of researchers, many American Indian communities are very wary of participating in research studies (Christopher, 2005). Therefore, it is not surprising that there is a lack of research about American Indian female adolescent sexual activities. One study on American Indian youth by Hallerstedt, Peterson-Hickey, Rhodes, and Garwick (2006) explored how familial and cultural ties are important to the health of American Indians. The majority of American Indian youth felt they could discuss personal problems, including sexual problems, with their parents and that their parents cared about them. Unfortunately, these findings did not disaggregate adolescents who were sexually experienced from those who were not. Therefore, it did not explore motivation or potential correlation of adolescent romantic or sexual behaviors to parental involvement. However, it did find a correlation between

sexual initiation at a very early age and potential partner violence. A separate study supported these findings as it explored high risk behaviors correlated to HIV exposure in inner-city American Indian females. Although the study did not focus specifically on adolescents, it presented an alarming finding that 44% of American Indian females experienced physical or sexual trauma. That is more than double the 20% lifetime prevalence in the national probability for women (Simoni, Sehgal, & Walters, 2004). The meager research on American Indian females was a significant factor determining their inclusion in this study. My research will assist healthcare providers and educators in how to best communicate with American Indian females about sexual health and partner violence.

Gender, race, and SES all operate within the larger concept of culture. These smaller, more manageable sub-categories allow more specific analysis of how adolescents form their complex sexual identity within the groups with which they interact. Understanding the motivation driving female adolescent romantic behavior cannot be explored without considering the overriding influence of culture. As discussed, there are cultural differences between adolescents in their romantic relationships, especially in regard to the age of initial romantic relationship, age of lost virginity, and balance of power in relationships. By understanding the cultural influences, stereotypical assumptions based on race can be minimized in order to provide greater insight about how adolescent females process conflicting messages. This will allow health educators, health providers, and parents to better tailor communication about romantic relationships and sexual activity to more completely prepare adolescent females for adulthood.

## Sex Education

Television series and mainstream movies often depict sex education as incredibly boring and irrelevant. It is characterized by the portrayal of an out-of-touch teacher dressed in clothes from 30 years ago who is either too eager or uncomfortably fearful of teaching the topic. Sadly, US sex education programs do not maximize their potential in informing adolescents about sex or the sexual health issues relevant to their bodies. If taught properly, and with the right mission, sex education classes have the potential to inform and mold the sexual development of adolescent females.

Formal sex education has been and continues to be a hot topic, heavily influenced by conservative policies that emphasize the perils of sexual activity to young people. This section will provide a historical perspective of the impetus for beginning formal sex education programs in the US, with a brief examination of the evolution of sex education curricula in terms of its messages to young females. It is important to look at the evolution of sex education and the current sex education curriculum provided adolescent females to understand how these programs influence sexual motivation and behavior. In this dissertation, I will examine the relative importance of whether adolescent females learn about reproduction from sex education programs in the school or from informal sex education messages from family and peers.

### *Early Sex Education Programs*

From 1918 through the 1920s (the pre- and post-World War I era), there was a Public Health Service (PHS) sex education campaign that sought to educate men and women, of all ages, about the perils of venereal disease (VD). It was the first US government sex education program with the objective of protecting the public health

(Lord, 2004). However, growing fears surrounding the perceived decline of sexual morality were at the root of the movement. Sexual mores began to change in the late 1800s when women began working outside the home. While working away from their families, young women had social freedom not previously experienced. Young working women were generally paid less money than men and sent portions of these wages home to their families. This imbalance of economic power between young men and women supported the practice of men treating women to gifts or recreational opportunities to which women frequently reciprocated with sexual favors (Bailey, 1988).

After WWII, adolescent behaviors began to change even more rapidly than after WWI. Adolescents were needed in the workforce, which provided them increased income. They received additional freedoms with access to the increasing availability of automobiles (Levine, 2002). As adolescents were experiencing increased freedoms, gender roles were undergoing changes, too. When young women lived and worked with their families, their romantic relationships were arranged by their families or a trusted employer. Male suitors would come to a young woman's home to court her under the supervision of family members. With the independence of working away from home and with access to an automobile, men became the hosts or the pursuers of romantic relationships. Additionally, the initial contact for romantic behavior shifted from traditionally supervised to unsupervised time with male suitors (Lord, 2004). This lifted constraints on sexual behavior in courting relationships.

At the beginning of the PHS sex education program, males and females were equally taught measures to control venereal disease and given equal responsibility in

preventing its spread. Eventually, PHS speculated that the male sex drive was stronger than that of females. This led to separate and different sex education messages to men and women. The messages to women placed them into two categories: 1) working women who were subject to male seduction leading to promiscuous behavior, and 2) women who were sexually passive in the role of wife and mother. Both groups were considered to be at high risk for contracting VD. Supposedly, promiscuous women were responsible for spreading the disease, and passive women were innocent victims of their husbands, who could be carriers of VD. The focus of the PHS sex education was to teach about the immorality and dangers of sexuality outside of marriage. Men were taught to curb their sexual urges, and women were taught to control male sexuality through virtuous conversation and sexually modest dress (Lord, 2004).

In shifting male sexual responsibility to women, the PHS presented two kinds of women: 1) those who were high-spirited and good companions for men, and 2) those who allowed improper relations with men out of ignorance. This division of women into two types (clean/decent and sexually curious/indecent) had two purposes. First, women were given a behavioral model to emulate. Second, the PHS was able to target educational messages based on the two behavioral types. The end result was that the PHS designed messages to encourage women to avoid immoral behavior and control male sexuality (Lord, 2004).

This early historical perspective provides some insight into socio-cultural changes. These changes resulted in the transition of romantic relationships from family partner selection with close supervision of suitors to more independent romantic choices with freedom of behavior for young adults and adolescents. This transformation led to a

government-created sex education program which increasingly emphasized different sexual expectations of men and women. The changes in the sex education program went from a curriculum inclusive of male and female participation and sexual responsibility to a curriculum that separated the sexes while putting a heavier burden on females to control male sexuality. Unfortunately, the injustice of women having the added responsibility of controlling male sexuality still exists in many of today's sex education programs.

*Recent Sex Education Programs*

As seen with the outbreak of VD in the early 1900s, the HIV/AIDS outbreak encouraged the government to evaluate sex education programs in the 1980s. Throughout the 1980s and 1990s, adolescent STD and pregnancy rates rose dramatically, and HIV/AIDS was becoming an epidemic. This led to another major public health initiative targeted to reduce expressions of adolescent sexuality (Centers for Disease Control and Prevention., 2002). The chosen education tactic to combat STDs was to teach the importance of abstinence. Thus, abstinence-only sex education programs were born. In 1982, abstinence-only programs began receiving limited government funding. In 1996, the curriculum of these programs received a major boost in government funding. Abstinence-only programs have grown exponentially since then in both the available funding and in the number of classrooms teaching this curriculum of sex education. Currently, sex education programs receive more than 100 million dollars per year in funding. A total of 1.5 billion dollars in federal funding has been spent in the past 12 years on these programs (Sexuality Information and Education Council of the United States, 2007b).

With the abundance of available money encouraging educators to teach abstinence-only curricula, it is understandable why it is the current trend of sex education. These programs teach the social, psychological, and physical health gains of remaining abstinent until marriage. Information about how to use contraception or prophylactic measures to prevent pregnancy or STDs is excluded from the curriculum. More specifically, recipients of the monies may not provide any information about contraception or prophylactic measures to avoid STDs or pregnancies (Howell, 2007).

Just as control over adolescent romantic relationships moved out of the home in the early 1900s, the topic of sex education has moved out of the control of the home and into the political arena. As with many political issues, two opposing viewpoints exist about the abstinence-only sex education programs. Proponents of abstinence-only education programs state that more teens are waiting longer to have intercourse (Aten, Siegel, Enaharo, & Auinger, 2002) which implies a decreased sexual risk resulting in delayed pregnancies and reduced STDs. In a study evaluating the *Sex Can Wait* curriculum, a popular abstinence-only curriculum, data suggested that high school students increasingly exhibited attitudes supportive of abstinence and expressed the intent to remain abstinent (Denny & Young, 2006). Other curricula are available to educators, with some abstinence-only programs obtaining pledges from participants to remain virgins until marriage (Levine, 2002).

The opponents of abstinence-only programs argue that teens who take pledges to remain abstinent until marriage are less likely to use protection or contraception if they become sexually active before marriage. Another criticism is that evaluative measures supporting intent and attitudes, such as the study mentioned above, do not measure

behavioral change. A major report, studying the effectiveness of abstinence-only programs was published last year, using the National Survey of Family Growth data set, Kohler, Manhart, and Lafferty (2008) compared and contrasted abstinence-only education, Comprehensive Sex Education (CSE), and a control group which received no formal sex education program. The subjects were adolescents who had never had sexual intercourse, which provided additional validity to the findings. Their results indicated that adolescents who received CSE had half the risk of teen pregnancy than those who received abstinence-only education and 40% of the risk of those who received no sex education. These results suggest that not only do Comprehensive Sex Education programs reduce sexual risks but that abstinence-only programs actually increase risks of teen pregnancy when preventative measures are not used.

Abstinence-only education opponents argue that teaching about issues of sexuality, such as health issues of sex including STDs and pregnancy, does not encourage teens to be sexually active. Eighty percent of adults support a form of comprehensive sex education that includes the concept of abstinence while also providing information about contraception and protection. This majority also disapproves of the government's massive investment in abstinence-only programs (Freking, 2007; Sexuality Information and Education Council of the United States, 2004).

Despite the 1.5 billion dollar expenditure on abstinence-only programs, two CDC reports on sexual health raise additional concerns about the effectiveness of abstinence-only classes. The first report shows pregnancy trends in the United States over the past 66 years. After teen pregnancy had steadily declined for nearly 35 years,

there was a rapid increase between 1985 and 1990. The rate of teen pregnancy was again on the decline from 1990-2000, which would suggest that some form of sex education was impacting adolescents. In 2005-2006, an increase in teen pregnancy occurred for the first time in a decade, leaving scholars wondering whether the increased funding and prevalence of abstinence-only sex education programs were contributing to higher levels of pregnancy (Centers for Disease Control and Prevention, 2008b).

The second CDC report, based on statistics gathered from 3.2 million teenage girls, estimated that one in four US females between the ages of 14 and 19 is infected with at least one of the most common sexually transmitted diseases, including human papillomavirus (HPV), chlamydia, herpes simplex virus, and trichomoniasis. This study was the first to report the combined national prevalence of the four most common STDs, which provided evidence of the heavy emotional and physical burden carried by many adolescent females (Centers for Disease Control and Prevention, 2008b).

The evidence continues to mount that abstinence-only programs are ineffective and the curriculum is filled with false and misleading information. Medical inaccuracies are taught about contraception, including the view that condoms are ineffective. Additionally, very rarely is there any discussion of the health needs of gay and lesbian adolescents. Despite the questionable results of abstinence-only sex education, federal funding for these programs continues to flow (Howell, 2007; Sexuality Information and Education Council of the United States, 2007b; Waxman, 2008).

Even with high levels of funding to abstinence-only programs, in the past two years a growing number of states have taken a proactive approach to protect the health

and well-being of adolescents by teaching more comprehensive curricula. In 2007, SIECUS identified 10 states that did not participate in the Title V programs (one of the federal funding sources for abstinence-only sex education). This left 12 million dollars in the budget unspent, which equates to one-fifth of the annual budget. The curriculum of these 10 states addresses abstinence as an option while also including information about contraception and safe sex practices, if sexual activity is chosen (Sexuality Information and Education Council of the United States, 2007b). A preliminary report for 2008 indicates that the number of states choosing comprehensive sex education programs over abstinence-only has more than doubled in one year, totaling nearly half of the states. Currently, only 28 states participate in the abstinence-only education programs, which reflects a changing belief that comprehensive sex education programs are a necessity for our adolescents (Freking, 2008).

In addition to sex education programs in school, some adolescents learn about sexual activity and sexual health from adult role models such as parents and other family members, and/or groups such as Girl Scouts. Moreover, many adolescents learn about sexual activity through conversations with their peers. In combination with the school programs, adolescents would seem to be fully informed about sexual health. Ideally, this would reduce the levels of risky sexual behavior in this country. As previously stated, adolescents still participate in such risky behavior. It is important to determine if there is a knowledge gap or a problem with motivation leading to risky sexual behavior. In this dissertation, I am examining the source of sex education to explore its effectiveness from a cultural perspective.

*Messages within Curricula*

As described previously, sex education programs have historically reflected and shaped the socio-cultural transformations of romantic relationships and the health concerns of the general population. Unfortunately, the programs are premised on female control of sexual activity within heterosexual relationships. Although Fine published *Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire* 20 years ago, the problems she found in sex education curricula remain as relevant today as they were in 1988. In fact, in revising Fine's original research, she and McClelland (2006) examined nearly 20 years of abstinence-only curricula to find that they still place disproportionate burdens on adolescent females in regard to sexual responsibility.

Fine (1988) originally argued that sex education programs are deficient in teaching adolescent females about their sexuality due to an emphasis on four major concepts that structure sex education curricula: violence, victimization, morality, and desire. First is the discourse of sexuality as violence through sexual acts such as sexual abuse, incest, and rape. The purpose for teaching about sexual violence is to promote sex-negative attitudes in hopes that adolescent sexuality will not be expressed. In other words, to promote abstinence until marriage, adolescents are taught that sex can cause them harm. Second, with the concept of victimization, young females learn that they are vulnerable to the male predator. This concept teaches adolescent girls to defend themselves against STDs and pregnancy. The adolescent female must be in control of the sexual situation and be the one to "say no." It is suggested that if premarital sex is avoided, victimization can be prevented since there would be no opportunity to become victim to STDs or pregnancy. Third, the concept of individual morality stresses that

adolescent female modesty, chastity, and abstinence until marriage are necessary to avoid one gaining a reputation of being a sexually immoral person who contracts STDs or pregnancy. An implication of this concept is that adolescent females' self-control and virtue should prevail over sexual temptations. The fourth concept addresses the topic of desire. If desire is mentioned in sex education programs, it is usually laden with reminders of the consequences that can result if sex is pleasurable: unwanted pregnancies, STDs, and emotional pain (Fine, 1988).

The sex education curricula examined by Fine (1988) reflected the messages of the PHS sex education campaign, mentioned earlier. She found that the curricula still warned females of the dangers of the male sex drive and the need to protect themselves from violence, victimization, immorality, and unbridled sexual desire surrounding sexual activity. After re-examining the modern sex education programs, Fine and McClelland (2006) assert that the same negative messages about sex and sexuality exist today. The question then is how these messages impact the decisions adolescents make about being involved in a romantic relationship, decisions about the quality of romantic relationships, and decisions they make about sexual activity within the relationship. This study will address these questions and probe to determine if these negative messages and burdens to the females impact their sexuality as adolescents.

## Peers

Adolescence is a time to develop personal and sexual characteristics that partially make up one's self-identity. As the adolescent personality is budding, there is frequently a need for separation from one's parents. Peers begin taking the lead in the adolescent's social network. Peer relationships play a significant role in adolescents'

separation from parents as an adolescent's emerging individuality develops (Connolly, Furman, & Konarski, 2000; Fonseca & Greydanus, 2007). As one might expect, peer groups with positive attributes provide protection against negative behaviors (Oman, Vesely, Aspy, McLeroy, & Luby, 2004), and peer groups with negative attributes contribute to poor decision-making and risky behaviors (Pedlow & Carey, 2004). As adolescent females separate from the family, in either a positive or negative way, and connect with peers, they often begin the journey into romantic relationships.

Antecedent social conditions to most romantic behavior are adolescents' friendships with peers. Same and opposite-sex peer friendships have the potential to influence romantic behavior in adolescents, and the culture of the adolescents often dictates the degree of influence (Cavanagh, 2007). The commonly discussed influential issues peers have on general adolescent decision-making range from drug use to hang-out location to performance in school (Santor, Messervey, & Kusumakar, 2000; Sim & Koh, 2003). In addition to these issues, peers can drastically influence decision-making about and within romantic relationships. Relationships with peers directs adolescents in deciding to get involved in a relationship, what activities to partake in while in the relationship, and what constitutes a good or bad relationship.

The peer group provides the social context of romantic relationships and helps influence the initiation of romantic development. Specifically, it helps to define appropriate romantic feelings, behaviors, and criteria for selecting romantic partners. Eventually, these romantic feelings and behaviors become internalized and adolescents are socialized into the romantic role as defined by their peers (Cavanagh, Riegle-Crumb, & Crosnoe, 2007). In order to feel part of the group, adolescent behaviors fall in

line with the socialized expectations. The expectations and the actions are not always congruent. This may lead some adolescents to behave in ways that they perceive their peers are behaving without determining their actual behaviors. I will explore whether there is a relationship between the sexual activities of adolescent females and her peers' sexual activities.

The quality of decisions made during dating is influenced by the age of the adolescent, according to cognitive development theory. Dating during the early adolescent years (11-14 years) is considered more problematic than dating during later adolescence (15-17 years), which is considered a positive activity associated with building social skills (Collins, 2003; Friedlander, Connolly, Pepler, & Craig, 2007). Adolescent dating typically occurs on a continuum through the developmental stages with a progression from mixed-sex peer group activity, to group dating, to dyadic dating outside the group (Friedlander, et al., 2007). This progression naturally assumes that females will have both same-sex peer groups and opposite-sex peer groups. Current research assesses the positive and negative aspects of both of these groups on adolescent decision-making.

*Same-Sex Peers*

Same-sex peer relationships usually emerge earlier than opposite-sex peer relationships and are typically the first relationship opportunities for experiencing intimacy and trust outside the family (Cavanagh, 2007). Females disclose interests and feelings about males within their peer group which can be the impetus for romantic notions and sexual activity. As discussed previously, females' perceptions of their peer

groups' romantic relationships may be predictive of their own romantic activity. Hence, peer groups set the tone for sexual activity (Cavanagh, 2007).

Adolescent females' peer groups also influence their safe sex practices and the timing of sexual initiation (Morrison-Beedy, et al., 2008; Reynolds & Repetti, 2006). The quality, patterns, and make-up of females' friendships may vary across cultural and class lines (Brabeck & Brabeck, 2006; Connolly, et al., 2000; Friedlander, et al., 2007; Halpern, Kaestle, & Hallfors, 2007), but generally, same-sex friendships among girls tend to be more intimate than same-sex relationships among boys (Brabeck & Brabeck, 2006). This study will examine how culture impacts whether peers communicate about romantic relationships. Same-sex relationships may do more than simply encourage or discourage sexual activity and safe sex choices. They have the potential to set expectations about the quality of romantic relationships in which females choose to be involved.

*Opposite-Sex Peers*

Through the natural development of childhood, females and males choose to associate strictly within the boundaries of same-sex friendships for many years. Many adults have silly memories of how "cooties" were shared and eliminated on playgrounds during elementary school. However, as the young children become adolescents, an interest in the opposite-sex develops and friendships between males and females become acceptable.

Opposite-sex peer groups serve as pools for potential romantic relationships and as arenas for practice dating. In our society, females are socialized to value friendships more than boys (Brabeck & Brabeck, 2006). Therefore, they are more likely than boys

to initiate and participate in opposite-sex friendships without romantic involvement (Cavanagh, 2007). However, when females enter into romantic relationships, they place special importance on maintaining the friendship aspect of the relationship. This strong desire to preserve friendship makes females more susceptible to sexual pressure emanating from the romantic relationship, if they feel that the friendship is threatened by refusing to participate in sexual activity (Haynie, 2003).

*Mixed-Sex Peers*

Opposite-sex relationships in adolescence are generally less intimate than same-sex relationships. Despite the difference in intimacy, the mixed-sex friendship groups have significant ways of enhancing adolescent development. For example, these groups are better than single-sex groups for providing arenas to develop sociability and the concept of romantic relationships across the sexes (Cavanagh, 2007). My research examines how friendships with males influence the decision-making process of young females by looking at romantic relationships in two ways. First, they will be analyzed according to whether participants included males in their peer groups. Second, I will examine how mixed-sex peer groups influence the age of adolescent girls' first serious romantic relationship.

*The Absence of Peer Groups*

Some adolescent females do not participate in peer groups and, therefore, lack peer group influence on decisions and behaviors. Some have no access to peers while others have chosen to isolate themselves. Little research has been conducted in this area. While one might determine that lack of peer group participation protects adolescents from negative peer influences, such as drug-use, illegal activities, and early

romantic behavior, it also restricts them from experiencing the positive influences of peer groups. Since dating typically follows the previously mentioned continuum which relies on peer groups, dating that does not follow the standard continuum is worthy of examination. This dissertation will examine how the direct absence of peers impacts decision-making in romantic relationships. Looking at the impact of not having a peer group will add to the general body of knowledge and allow a comparison with adolescents who have peer groups.

## Family Influence

As mentioned previously, family structure has changed over time. Many years ago, the family was structured such that parents, children, and extended family lived nearby and participated in each other's daily lives. In today's global world, the structure of the family might resemble that of a spider web: a central core with branches extending all over the world in spatial terms. Despite how much families have spread out, in most families, children grow up in a home with at least one parent before venturing off into independent lives.

A substantial developmental task in the life of adolescents centers on the establishment of self-identity, which supports independence. Accomplishing this task requires a certain amount of separation and independence from family, but even throughout the struggle of separating from family, the adolescent continues to experience the family as a significant influence on his/her life (Friedlander, et al., 2007). For instance, many parents and teenagers argue about curfew. Teenagers want more time away from home, separating them from the family, while the parents set limits on the time apart. This naturally occurring, necessary struggle within families has

kept researchers active for many years in studying the impact of family life on adolescents. I will examine a range of adolescent female relationships by considering the interaction with both parents, between mother and daughter, between father and daughter, and among siblings. All of these influences will then be examined for their impact on the development of romantic relationships and decisions within those romantic relationships.

*Parents as a Unit*

Children today are less likely to live in homes with both biological parents than they are to live with a single parent or some form of step-parent family arrangement. Although the majority of adolescents and adults from single parent and step-parent families grow up to be well-adjusted, the journey is fraught with challenges. The literature reflects that children and adolescents from single parent and step-parent families continue to demonstrate riskier behavioral problems than their peers living in low-conflict, biologically intact homes with two parents (Baril, Crouter, & McHale, 2007; Jacobson & Crockett, 2000).

Two-parent biological families are better able to provide more monitoring of adolescents (Harris, et al., 2007), which is correlated to less sexual activity. A dilemma for some parents is deciding how much they should monitor the activities of their children since the adolescents often resent the restriction of their freedom. Jacobson and Crockett (2000) found that high levels of parental monitoring reduced levels of sexual activity. Friedlander, Connolly, Pepler, and Craig (2007) found that lax parental monitoring was correlated to children who initiated dating earlier than those with

stricter monitoring. While both studies illustrate the importance of parental monitoring, neither study considered pubertal maturation nor peer involvement.

The presence or absence of parental monitoring sometimes is discussed in terms of the amount of trust that exists between the parents and child. Borawski, Levers-Landis, Lovegreen, and Trapl (2003) explored how trusting relationships with parents impacted girls and boys differently. More specifically, Borawski et al. explored the relationship of both parents with sons and daughters to determine if a trusting relationship with relaxed parental monitoring would influence a delay in first intercourse. They found that daughters were more likely to delay first intercourse if they had a trusting relationship with their parents, but a trusting relationship had no influence on first intercourse for sons.

Trusting relationships which would seem to support conversation about sexuality are important components of family communication. According to a national survey, 47% of the adolescents perceived their parents as being the most influential factor in their decision-making about sexual behavior (National Campaign to Prevent Teen Pregnancy, 2007). In a recent study by Tolma, Vesely, Oman, Aspy, and Rodine (2006), teens who were sexually active and educated about the use of contraception by their parents were more likely to use contraception than those who were not taught by their parents. These studies indicate that there is a need to explore whether parents are discussing romantic relationships with their adolescent daughters and to further determine the messages they communicate to them.

Analytically, there are problems in delineating age-appropriate discussion of sex education and the use of parental monitoring. Age-appropriate sexual discussions, like

degrees of parental monitoring are confusing for parents. For instance, it is not clear when parents should institute higher levels of discussion and diminishing amounts of monitoring (early, middle, or late adolescence). Additionally, the literature does not differentiate between influences on females and males with regard to parental monitoring. Also, the literature does not evaluate how the parental monitoring relates to risky sexual behavior. I will attempt to address some of these issues by determining whether interviewees felt that having strict or highly involved parents reduced risky sexual behavior. In addition, since a large portion of American families are not composed of both biological parents, relationships between adolescent daughters and biological parents will be considered.

*Mothers*

In an idealistic, *Hallmark* kind of world, all biological mothers and daughters would experience relationships full of unconditional love, respect, trust, and happiness. But this is not a *Hallmark* world. In fact, some adolescents do not have an involved biological mother, but have instead a grandmother, aunt, or special family friend raising them. In the mid-1960s, Stack (1974), conducted interviews and participant-observation among members of two multi-generational extended black families. She showed how the role of mother sometimes shifted from the biological mother to a substitute mother. If an adolescent became pregnant and was not mature enough to raise her child, the responsibility was assumed by her mother, older sister, or aunt. The person responsible for the care of the child was referred to as “Mama.” For the sake of this study, the adolescent daughter’s perceived relationship with the biological mother or mother

figure will be explored since research has shown that a positive mother-daughter relationship benefits both mother and daughter emotionally.

Several studies have examined how the positive influences of the relationship with the mother help adolescent females avoid risky sexual behavior. In a study examining sexual abstinence in urban girls, the mother-daughter relationship was the most important relationship in the adolescents' lives. They reported that their mothers shared their thoughts and feelings about males, romance, and sexual activity. The communication themes between the mothers and daughters with regard to sexual activity alternated between positive and negative messages. The positive messages focused on confidence and esteem-building for the adolescent female. The negative messages focused on males' desire for sex, their disrespect for sexual partners, and their lack of fidelity to the sexual partner (Morrison-Beedy, et al., 2008). The study found that the open channels of communication between the mother and daughter promoted abstinence in the adolescent females. In other studies, Hutchinson, Jemmott, Jemmott, Braverman, and Fong (2003), Doswell et al. (2003), and Aronowitz and Munzert (2006) found that a strong mother-daughter relationship provided protection from risky sexual behavior in African-American adolescent females through delayed initiation of first intercourse. Sieving, McNeely, and Blum (2000) and Resnick et al. (1997) derived their findings from the National Longitudinal Study of Adolescent Health and broadened their conclusion to indicate that a mother's influence delays initiation of intercourse across cultures. Together, all of these studies argue that despite cultural difference, the mother-daughter relationship has an impact in delaying adolescent female sexual activity, which in turn reduces risky sexual behavior.

Unfortunately, the benefits of the mother-daughter relationship can be tainted by the communication about adolescent sexual activity. As stated previously, many of the messages that adolescent females receive about sexual experiences from their mother have a negative tone. Girls are generally given negative messages about boys and are guided to avoid sexual experiences altogether (O'Sullivan & Meyer-Bahlberg, 2003). One study that examined the emotional aspect of female adolescent sexual activity found that positive aspects of the sex act they experienced contrasted negative messages received from their mothers about sex. More specifically, females who had recently engaged in sexual activity described the event positively, as it made them feel attractive and more confident. They also reported that the negative messages about sexual activity from their mothers caused them to see their mothers' messages as lacking credibility. Therefore, respect for their mothers was lessened in some cases (O'Sullivan & Hearn, 2008). While this study shows that the communication between mother and daughter can negatively impact the relationship between the two when the daughter's experience differs from the mother's message, it does not address how the negative sexual messages impacted females' sexual identity. Additional research is needed to explore the lasting impact of these messages on adolescent female's sexual development and identity. This dissertation will examine how negative messages about sexual activity impacted adolescent romantic relationships.

From the existing research, it appears that mothers use negative messages in order to delay initial intercourse. While this postpones the potential hazards of sexual activity, it does not address the bigger picture. Adolescent females need continuous age-appropriate messages about healthy romantic relationships as they develop into women.

By understanding the long-term impact of the negative messages, mothers will be able to better tailor messages so that intercourse might be delayed and the romantic relationships that develop subsequently might be healthy.

*Fathers*

According to Kelly (2001), many fathers experience a profound love for their daughters that they describe as unconditional. As with mothers, having a person acting in the role of father is more important than the biological connection to a father. According to Stack (1974), the role of father can be carried out by a strong male figure in the family. It might be an uncle or stepfather who is willing to make financial contributions as well as spend time with the children. The biological father does not automatically have a role with the children if he does not acknowledge his paternity.

Daughters who have experienced a healthy, intimate relationship with their fathers understand the lasting impact of that bond. However, scholars have only given limited attention to the impact of a father's involvement with his daughter. For instance, in the Morrison-Beedy et al. (2008) study about the practice of abstinence in urban girls, fathers were barely mentioned as having an influence on their daughters. However, there are a few studies that assess the impact of the father-daughter relationship in terms of the adolescent developmental growth.

While not addressing adolescent sexuality specifically, several scholars have concluded that a troubled father-daughter relationship produces negative physical and psychological growth for the daughters. In a study of female eating disorders, Jones, Leung, and Harris (2006) asserted the female's perception of her father as rejecting or overprotective led to higher levels of specific dysfunctional behaviors such as anorexia

and bulimia. Another study found that significantly more depression occurred in girls whose fathers were either absent or uninvolved in their lives (DeMinzi, 2006). Call, Mortimer, and Shanahan (1995) asserted that poor father-daughter relationships negatively impacted the development of competence (the ability to be self-directed with adequate skills to contribute adult-like behaviors to the smooth functioning of the family) in adolescent females. Eitle (2006) found that adolescent females living with single fathers were at increased risk for deviant behavior such as carrying a handgun, stealing a motor vehicle, attacking someone with the idea of seriously hurting them, and/or being arrested. Finally, in a study comparing peers' psychological profiles between teenage mothers and non-teenage mothers, teen mothers were more likely to report having fathers classified as distant, withdrawn, and unsupportive (Ozler & Tari, 1992).

Two additional father-daughter studies addressed how influential fathers are on their adolescent daughters. First, Tolman's (2002) study argued that the father had a strong effect on his daughter's beliefs even if she did not agree with his. More specifically, Tolman considered the influence of fathers who believed that females who expressed romantic desire or wore flirtatious clothing were responsible, if they were raped. While the daughters stated they did not have the same beliefs as their fathers, they were still influenced by their fathers' belief systems. The second study assessing a father's influence looked at the relationship between 11-year-old girls and their fathers. The longitudinal study focused on general female development and found that girls at age 11 began to see their fathers' humanness and began to express an appreciation of and concern for their fathers' problems. Along with this awareness, the girls learned to

minimize their emotions for the sake of their fathers' discomfort with emotional issues (Gilligan, 1991).

While the above studies indicate the importance of a fathers' influence on daughters, none specifically addresses their impact on their daughters' sexual development, involvement in romantic relationships, or decisions within the romantic relationships. Bussey and Bandura (1999) viewed modeling as a significant factor in human development. By ignoring how fathers model the male role for their daughters, scholars are missing a key element in adolescent development. This study will attempt to fill this gap by assessing what roles fathers played in educating their daughters about reproduction and/or discussing romantic relationships.

*Siblings*

Sisters and brothers greatly impact the household life of any family. Parents often must allocate their time amongst multiple children; deliver them to various play dates, schools, and sports; and discipline each one in the most effective way. Due to sharing the attention of parents, it is logical to assume that siblings influence the psychological development of each other. Characteristics of the female adolescent's relationship with her sibling, whether it is positive or negative, may be a key influence on her romantic behavior. Several scholars have investigated how siblings influence each other.

Some studies have examined how siblings impact the sexual development of young females without differentiating between brothers and sisters. For example, Konreich, Hearn, Rodriguez, and O'Sullivan (2003) researched how older siblings impacted the sexual interest of younger sisters. They found that females with older

siblings had fewer sexual interests than their peers without them. The presence of an older sibling led the younger sibling to have strong associations with more conservative gender roles in sexual interactions. Contrary to popular opinion, this strong gender role identification for the younger female sibling seems to encourage disinterest in sexual activity and encourage a sense of self-efficiency or power that delays sexual activity. However, the study did not explore attitudes or behaviors among the siblings that might have supported the findings.

Other studies have specifically looked at how sisters and brothers impact the sexual development of adolescent females. It has been found that older sisters with babies influenced younger sisters to adopt a more conservative, or restricted-behavior with regard to sexual activity. This counters the societal opinion that older sisters with babies negatively impact younger siblings (Kornreich et al, 2003). Brothers appear to have an equally substantial impact on younger sisters. A study by Snyder, Bank, and Burraston (2005) found that when older brothers are involved in deviant behavior with little parental discipline, younger siblings are influenced by the older brother's behavior. In other words, the younger sibling will emulate or participate in the older brother's deviant behavior. In another study, the double-standard of female and male sexuality was addressed. Brothers advised younger female siblings to avoid sexual activity even if the brothers were sexually active with several females themselves (Morrison-Beedy et al, 2008).

It appears that brothers and sisters of adolescent females have an impact on their development and sexual activities. However, researchers have not fully explored the brother-sister relationship with regard to adolescent sexuality. Further, very little data

exists about the impact of half- and step-siblings on adolescent's sexual development. Understanding the variable impact of sister and brother and older and younger siblings' relationships may help parents monitor the romantic involvement of each child in the family. Therefore, this study will examine how siblings influence the construction of ideal romantic relationships and discussion of romantic activity.

Understanding how familial relationships impact adolescent females by both the sexual messages conveyed by the family members and the significance assigned to relationships needs to be explored. Additionally, it should be determined how guidance and support of the family during the development of romantic relationships influence the adolescent female. Ideally, this information would allow parents and older siblings to aid young girls in their sexual development. Parents should consider formal training to help them communicate effectively about issues of sexuality with their adolescents (Klein & Ackerman, 1995).

## Summary

The developmental struggles adolescent females faces on a daily basis have some similarity to the struggles their parents faced in their adolescence. In addition to the usual worries about what to wear, who to be seen with, what extracurricular activities to participate in, and how to do well in school, there is added pressure to participate in sexual exploration. New technologies contribute to the pressures that are unfamiliar to many adults. More research needs to be done to inform scholars and parents how to best help their children through these changing times, especially regarding their budding sexuality.

Understanding how the adolescents cope with the issues they face is critical to understanding how to best guide them in their decisions. Policymakers, health providers, school educators, and parents will be able to tailor messages within the cultural, peer, and familial contexts. The result will hopefully better inform adolescents about their own sexual health related to their romantic relationship.

# CHAPTER III – REPRODUCTIVE HEALTH: PAST AND PRESENT

Two of the great strengths of the United States are the civil liberties and personal rights upon which this country was founded. Adolescent females today may consider that the reproductive health care they receive has always been one of their personal rights. This chapter will discuss the history of reproductive rights in the US and the challenges encountered in the struggle to obtain those rights. More importantly, I will describe how some reproductive rights are being reduced and revoked without adequate discussion and debate, two essential components part of the democratic process.

US women's history has documented state and federal legislation that has inhibited women's rights. Unfortunately, from my experience as a nurse practitioner, educator, and mentor, it appears that many females are uninformed about the political and social issues in this country that impact their reproductive health, including access to contraception and abortion. One common goal of lawmakers restricting females' rights is to keep them in their traditional role as homemakers, which pervades all issues presented in this chapter. Society has long feared that political freedoms will fuel the transformation of the domestic role of women. Ginsburg (1989) explored this fear more than 25 years ago when she studied a community torn between the pro-choice and pro-life movements. In Fargo, ND, the pro-life movement feared that the traditional functions of domesticity and nurturance practiced by females were threatened by the establishment of an abortion clinic by the pro-choice movement. In other words, political issues were influenced by fears that the pro-choice movement, giving females control of their reproduction, would change the structure of their society. The pro-life

community feared that, with more choices, women would no longer be the primary homemaker and caretaker of the children. This case study exemplifies how the political movements of the past mimic the political movements of the present. Case after case will illustrate this disturbing trend of limiting females' access to health care in order to keep them subservient in American society.

As will be discussed in the analysis section, the social values placed on women's health issues and access to health care have implications for adolescent and adult females in regard to their developing sexuality. As adolescents witness what personal health choices are available to them, they begin to formulate an understanding of what control they have over their own bodies. This equates to their perceptions of power they have over themselves, within their romantic relationships, and in their roles at home and in society. Hence, understanding how society and government have controlled health care for all females of reproductive age is critical. Women's history documents and analyzes the politics of birth control, the legislation of pregnancy prevention and management, and the development of well-women health care in the US.

## Political History of Birth Control

From a historical perspective, scientists have understood the process of reproduction for a very short period of time. For centuries, patriarchal societies believed males created life and deposited it in females, who then housed that life until it was ready to survive outside the womb. In ancient times and well into the 20$^{th}$ century, as is currently in parts of Third World or developing countries, females tried to control their reproduction with the use of herbs and roots. Before the discovery of barrier methods and the use of hormones, women helped other women abort without legal repercussions.

Abortion was a method of birth control that did not become illegal until the 1880s in most of the US (Boston Women's Health Book Collective, 1998). Options other than abortion began to appear in 1839, when Charles Goodyear invented several mechanical devices to prevent pregnancy through barrier contraceptive methods, including condoms, cervical caps, and diaphragms. These barrier methods were thought to block the life created by man from entering the woman. It was not until 1843 that scientists discovered sperm entered the female, connected to an egg, and then created life (American Experience., 2002). This discovery was important to more people than just scientists and doctors. It showed that life was created by both men and women instead of just men, which challenged the centuries-old belief that men controlled life.

In the 1870s, feminists who sought the right to control their sexuality and reproduction became driving forces for birth control. Until then, abstinence was the only widely known method of preventing reproduction, but it was not considered a viable option for married women (Gordon, 1986). Intercourse is a marital right and women were expected to be subordinate to men, which prevented the refusal of sexual intercourse in marriage. Despite having developed barrier contraceptive methods in 1839, it was not until the 1870s that such birth control methods became available to the general public. Women could obtain these devices from pharmacies, mail order catalogs, and dry goods stores (American Experience., 2002).

As birth control availability, and public awareness about it, increased, divisions in public opinion developed. In general, public opinion fell into two camps: those who believed that females should maintain domestic roles by staying in the home to raise children and those who believed females should have the right to control their own

reproduction. A less discussed concern about birth control was rooted in managing the growth and culture of the American population. For example, females of the dominant culture and of the upper class had access to birth control. This allowed them to drastically reduce the number of children they produced in order to pursue an education and a professional career. In contrast, the population of immigrants, such as the Irish, Italian, and Jews, was growing. Society feared that the elite class would dramatically decrease in size and lose power to the growing numbers of immigrants. Hence, birth control created two societal fears. The first fear was that the lower classes would have drastically greater numbers of children, who could become more powerful than the elite. The second fear was that increasingly educated elite females would refuse to maintain their subordinate domestic roles, resulting in the disempowerment of their husbands (Beisel & Kay, 2004).

Acting on these two fears and additional concerns about the morality of America, Anthony Comstock, an influential New Yorker, changed the course of reproductive politics in the second half of the nineteenth century. He believed that birth control was the reason New York City streets were filled with morally abhorrent sex traders and prostitutes. In response to this, in the early 1860s, he began supplying information to police to organize raids to crack down on the sex trade industry. In addition to his revulsion of the prostitutes, he was offended by the availability of and marketing strategies for birth control to the public. Using his political influence and power, he lobbied for legislation to support virtue and morality in Congress. In 1873, his efforts produced the first anti-obscenity law, The Comstock Act. It banned contraceptives and made it a federal offense to disseminate contraceptives through the

mail or across state lines. The US was the first nation in the Western World to pass such legislation (Tone, 2002).

The law was mostly ignored until 24 states passed their own versions, reinforcing the illegality of birth control use (Tone, 2002). As enforcement of the law increased, birth control was forced underground, which placed extreme hardships on the family lives of poor and middle-class women. Poor females were most drastically impacted by the lack of access to birth control. They had frequent pregnancies, which compromised their personal health and drained available resources to provide adequately for their expanding families. For middle-class women, since they were unable to control the number of children they birthed, they also had less access to higher education and professional opportunities. Both females of means and females of poverty felt the hardships of the government dictating their reproductive choices, but for different reasons. In an effort to improve the overall conditions of women, women of means began the first women's movement in the nineteenth century (Ryan, 1992).

One of the founding pioneers fighting for reproductive freedom was Margaret Sanger. As one of 11 children from a poor family, she sought a nursing career as a way to avoid the burdens her mother experienced. In 1912, when she began her nursing career, females of nobility frequently cared for the poor and described their work as meaningful and fulfilling. However, Sanger had a different experience as she found the conditions of extreme poverty very disturbing. In her writings, she described the lack of access to and limited knowledge about birth control, major factors contributing to the cyclical conditions of poverty. She saw that, in general, the population had no knowledge of pregnancy prevention other than abstinence, which was not an actual

choice. Many patients asked her for the recipe to keep from getting pregnant as they believed rich people had a secret recipe. Sanger also described seeing as many as 50-100 females in New York, lined up to visit an illegal five dollar abortionist (Sanger, 1977).

While she witnessed many heart-breaking situations, there was one particular medical situation which prompted Sanger to vow to improve reproductive rights. She was providing nursing care to a poor woman who had tried to self-abort, was suffering from sepsis, and was near death. The woman and her family were without enough food to eat nor clothes to wear. The woman was treated for sepsis by a physician who chastised her for the self-induced abortion. When she asked the physician how to prevent another pregnancy, he told her to have her husband sleep on the roof. The woman regained her health, and became pregnant again, shortly afterwards. This time she died from the complications of a self-induced abortion. After this case, Sanger fought to find solutions for females who wanted birth control to prevent other life-ending tragedies (Sanger, 1977).

Sanger felt so strongly about the positive impact of birth control on females' lives that, in spite of the Comstock Act, she gave lectures and wrote and circulated a newsletter encouraging females to have fewer children. In her work to overturn the Comstock Act, she was indicted for nine violations of the act, although the charges were eventually dropped. Despite these and other challenges of the law, she did not give up her cause to provide females access to birth control. In 1916, Sanger and the National Birth Control League opened the first US birth control clinic in Brooklyn, NY, a precursor to the International Planned Parenthood Federation (Sanger, 1977).

Sanger had a long-term goal that one day females would be able to take a simple, safe pill to control fertility. However, in the early 1900s, the clinic had very limited contraceptive options for women. By 1920, the rhythm method of birth control was developed, which identified what days to be abstinent based on a woman's fertility cycle. Since a device did not need to be purchased for this type of birth control, it was a method that did not violate the Comstock Act. Ten years later, the Catholic Church made a moral judgment approving the rhythm method and condemning all other methods as sinful and unchaste. Barrier methods required a physician to fit them, were expensive, were hard to obtain and, most importantly, were illegal. Barring other limited options, women were encouraged to try the rhythm method (Tone, 2002).

By the Great Depression, pharmaceutical companies marketed a large selection of feminine hygiene products with a secondary use as contraception. These hygiene products proved to be ineffective birth control and many times injurious to women's health. Women continued to feel a desperate need to control their pregnancies and would risk injury in an attempt to control their reproduction. In 1936, relaxation and prevision of the Comstock Act occurred in the US District Court ruling of *US v. One Package.* The ruling allowed doctors to distribute contraception across state lines, which set the precedent that distribution of contraception was part of medical practice. Seeing contraception as a healthcare issue, instead of simply a moral issue, initiated the journey to legalize birth control (American Experience., 2002) .

By the 1950s, almost 60 years after the discovery of hormones, Sanger's long-term goal of a birth control pill (oral contraceptive) became a reality. The first small, human clinical trial of the Pill occurred in 1954, under the guise of fertility

enhancement, since clinical trials involving birth control were illegal in many states. The results of the study proved that the Pill controlled ovulation, but the sample size was too small for drug approval by the Food and Drug Administration (FDA). The use of contraception was still illegal in the 1950s, making it impossible to conduct the large-scale clinical trials required for FDA approval. These restrictions required conduction of the official clinical trials to occur in Puerto Rico. The dose of the early trial pill was set at a high strength to insure efficacy. The high doses prevented ovulation but also carried high risks of side effects. Through a series of trials and errors, the Pill was approved by the FDA in 1957 for the use of treating menstrual problems but not birth control, as the latter continued to be illegal. In 1959, a large number of women, in order to avoid the issue of birth control, professed to develop severe menstrual problems in order to obtain prescriptions for the pill. Only one pharmaceutical company carried the product, and it made massive profits (Tone, 2002).

As word spread of a pill that could be used to control reproduction, social unrest arose concerning the involvement of government in private family matters. In the same year, 1959, President Eisenhower made a statement at a press conference proclaiming that controlling fertility was not a proper government function or activity (Solinger, 2005). The political climate was beginning to change to recognize the need for a safe and effective form of birth control for women.

In 1960, three years after the original approval of the Pill for menstrual problems, the FDA approved the use of the same pill for birth control. However, it remained illegal in several states which restricted its distribution. In order to bring awareness to states' restrictive laws, Dr. C. Lee Buxton (chairman of the Yale Medical

School's Department of Obstetrics and Gynecology) and Estelle Griswold (executive director of Connecticut Planned Parenthood) strategically opened four Planned Parenthood clinics in December of 1961. They were promptly arrested, which achieved their goal to bring national attention to restrictive state laws. This was the beginning of the long, four-year legal battle posed by *Griswold v. Connecticut*. The Supreme Court ruled that states did not have the right to limit a couple's right to privacy, which gave couples the right to use birth control (Garrow, 1998).

Even though the Supreme Court's ruling appeared to allow women to make their own choices about reproduction, the ruling actually applied only to married women. It took an additional eight years for single women to be granted the same reproductive rights to privacy given to couples. In 1972, the Supreme Court ruling on *Eisenstadt v. Baird* declared that a state could not block the distribution of birth control to a single person (Garrow, 1998).

After almost 100 years of restricting women's reproductive choices, the government not only reversed its decision about restricting birth control, but also began supporting birth control for the poor. President Lyndon Johnson, in 1964, pushed for legislation to provide federal funding and support for birth control to poor people. This legislation was not well received by the National Association for the Advancement of Colored People (NAACP). In 1967, the NAACP accused Planned Parenthood of targeting poor minority neighborhoods for distribution of birth control in an effort to reduce the population of African-Americans and other minorities, i.e., as an instrument of racial genocide. This strong accusation was not unfounded considering a history of discrimination against African-American in the US. Their fertility was controlled by

Euro-Americans during slavery to increase owners' profits. In the 1950s and 1960s, African-American women who entered the hospital to deliver babies were frequently sterilized without their consent. Although African-American women shared the fear of genocide with the NAACP, they also had the same need as Euro-American women to control their fertility. African-American women activists sought to transcend racial politics and protect the individual rights of African-American women to control their fertility, which helped increase access to birth control for the poor (Caron, 1998).

Finally, by the 1970s, supported by the Civil Rights movement, women of all races, incomes, and status appeared to have equal reproductive rights. These rights did more than simply allow women to prevent pregnancies. In addition, they were steps toward achieving the overall goal of the feminist movement: to give power to all women to control and protect their own lives. Women in poverty had the power to protect their own health by reducing the number of unwanted pregnancies, and women of means had the power to seek higher education and/or careers by reducing the number of unwanted pregnancies. As the discussion of pregnancy management will address, the fight for women's equal rights was far from over after winning reproductive rights. However, developing and legalizing relatively safe birth control, which prevented unwanted pregnancies, was far more responsible for liberating women than the legalization of abortion (hooks, 2000).

## Pregnancy Management Legislation

Despite a century of activism surrounding reproductive rights, abortion is a controversial topic. Earlier, abortion was used as a method of birth control prior to learning the physiology that made it possible to control reproduction with barriers or

pharmaceutical methods. Birth control allowed women to regulate their fertility, and abortion allowed them to choose how to manage their pregnancies. In both cases, politicians and segments of society have had highly oppositional opinions. However, the controversy over abortion is more heated regarding the issue of terminating pregnancy as opposed to pregnancy prevention by using birth control. While these two issues seem quite different, the separation between contraception and abortion is being blurred by recent legislative decisions as vehicles to restrict women's reproductive rights.

Abortion in many other countries is considered a personal choice, without governmental control. Through the long political debates about abortion, the public generally falls into one of two camps: pro-choice and pro-life. The pro-choice proponents argue that the government should not interfere in a woman's right to privacy, which should supersede any government ruling over a woman's choice to continue or terminate her pregnancy while the pro-life proponents argue that a woman should not have the power to terminate a pregnancy.

Each group's argument for or against abortion is complex and rests on personal and political issues. For example, pro-life advocates assume that abortion is a threat to the mental health of females. Much research has been conducted to explore post-abortion health outcomes. A recent report from the American Psychiatric Association (APA) task force reviewed all the peer-reviewed research conducted since 1989 and found that there is no conclusive evidence that a single elective abortion for an unwanted pregnancy causes mental health problems for an adult female (Major, et al., 2008).

The topic of abortion repeatedly appears in politicians' campaign platforms in all levels of government. Until the middle of the nineteenth century, abortion was not a political issue. Women had the right to choose how to manage their pregnancies. By 1900, most states had adopted individual statutes making it illegal to obtain or perform abortions. In 1972, abortion became a federal issue when the Supreme Court ruled in *Roe v. Wade* that women should have the legal right to have an abortion. This ruling helped reduce the number of underground, dangerous abortions, improving the health of women and their families (Johnson, 2008).

The federal legal protection of the right to abortion still exists today, but restrictions have been legislated in many states. The Gag Rule, RU 486, partial-birth abortions, emergency contraception, and parental informed consent have further complicated the status of women's reproductive rights. These restrictions pose a threat to women of all ages since they dictate health care options. As stated in the literature review, available health care options impact adolescent sexual development in profound ways which is why they need to be discussed in this dissertation.

*Abortion*

Abortion is seldom spoken about on a personal level in polite society, but statistics show that it is a common pregnancy outcome across all cultures and social classes. However, some segments of the US population have higher abortion rates. According to national statistics, almost one in four females will choose an abortion during their lifetime. Twenty-two percent of all pregnancies end in abortion. Each year, 2% of females, age 15-44, have an abortion, and 50% of all abortions are received by females under the age of 25. African-American women have 37% of abortions; non-

Latina Euro-Americans has 34% of abortions; Latinas have 22% of abortions; and females of other races have 8% of abortions. Nationally, the incidence of abortion decreased in 2005 from the previous period of 1973-2004, and the number of US abortion providers declined by 2% between 2000 and 2005 from 1,819 to 1,787. In 2005, 87% percent of all US counties lacked an abortion provider, with 35% of the female population living in those counties (Guttmacher Institute, 2008a). Nationally, the abortion rate among females living below the federal poverty level ($9,570 for a single woman with no children) is more than four times that of females living 300% above the poverty level (44 vs.10 abortions per 1,000 females). This is partially due to the rate of unintended pregnancies among poor women (below 100% of the poverty level) being nearly four times that of women 200% above the poverty level (112 vs. 29 per 1,000 females) (Guttmacher Institute, 2008a).

In Oklahoma, where my research is being conducted, the incidence of abortion has not declined at the same rate as the national average. Abortion remains relatively stable with a 6% increase from 2002-2006. In 2002, the incidence of abortion in Oklahoma was 6,215, and it climbed slightly in 2006 to 6,595. There is a disparity between the incidence of abortion and the racial population proportions in Oklahoma. The racial breakdown of Oklahoma's population is the following: Euro-Americans 78.3%, American Indians 8%, African-Americans 7.8%, and Latinos 6.9%. However, the breakdown of abortion performance by race is: Euro-Americans 47.2%, African-Americans 18%, American Indians 7.5%, Latinas 6.3%, and Other 21% (Guttmacher Institute, 2008b). American Indian and Latinas receive abortions in proportion to their population ratio. Euro-Americans receive abortions less than their population ratio and

African-Americans receive more than twice that of their population ratio of abortions causing questions to be raised about health care access and use.

Oklahoma uses no state or federal funding to support abortions (Sonfield, Alrich, & Gold, 2008). This poses an undue hardship on females at the poverty level whose only source of health care insurance is funded by the state or federal government. Oklahoma City, the largest city in the state, has no clinic for a medical abortion. The nearest clinic is located 20 miles away, and only two (Cleveland and Tulsa) of the 77 counties have a clinic for medical abortions (Guttmacher Institute, 2008b). This suggests that Oklahoma restricts abortions simply through lack of access to clinics. Many possible reasons exist for the small number of clinics, such as religious preferences of the state, lack of funding or dangerous working conditions for the clinic employees.

Abortion is a hot topic for people across the state and in more conservative areas of the country. Despite *Roe v. Wade* and subsequent court rulings protecting a woman's right to an abortion, many local communities actively oppose abortion and actively oppose its members exercising that option. Perhaps this limited access has contributed to the reduction in abortions nationally, but it does not explain why Oklahoma has experienced a slight increase from 2002-2006. While this dissertation project will not address this question, it will consider how the right to an abortion informs adolescents' personal health decision-making.

*Gag Rule*

The Gag Rule imposed during the Reagan-Bush era in 1988 was seen by many as the first step toward eventually overturning *Roe v. Wade*. The Gag Rule, upheld in

the case of *Rust v. Sullivan* in 1992, stated that federal funding could not be used to perform an abortion. Additionally, healthcare providers working in family planning services using federal funding were prohibited from discussing the option of abortion with their patients. Opponents to the ruling objected on two grounds: first, the ruling showed prejudice against poor women who relied on Medicaid for their medical needs, reversing the original reasons for which federally-funded family planning programs were created; and second, it imposed parameters on the doctor-patient relationship that previously had received sacrosanct privilege (Rosenfield, 1993).

The Public Health Service Act, also known as Title X, was established in 1970 to provide federal funding for family planning services that were widely available, comprehensive, and voluntary. Its purpose was to decrease the number of unwanted pregnancies in the US (Shapiro, 1990). Title X allowed all females access to comprehensive information about birth control options and abortion. The Gag Rule eliminated socioeconomic equality because affluent females had access to private medical care with all birth control options, while poor females were subject to restricted services (Smolowe, 1991). In effect the Gag Rule limited the option of abortion for poor women and/or contributed to the delay of receiving abortion services. First trimester abortions (12 weeks or less gestation) are safer and more affordable than second trimester abortions. A delay in receiving an abortion posed a greater health risk for poor females. The two-tier healthcare system in our nation was once again reinforced due to federal regulations.

The second argument dealt with the Gag Rule's interference with the provider/patient relationship in federally-funded healthcare clinics. Most Title X health

care was delivered by nurse practitioners, midwives, and social workers (Smolowe, 1991) who followed standards of practice similar to physicians. These standards of practice mandated that the healthcare provider ensure patient-centered rights that included accurate and complete information about their health conditions. The Gag Rule directed all healthcare providers working in the federally-funded family planning clinics to answer all questions about abortion with the pat reply, "This project does not consider abortion an appropriate method of family planning." Providers feared that patients, who frequently had no other access to health care, would construe the message to mean that abortion was not a viable option for their situations (Smolowe, 1991). From a healthcare provider perspective, the Gag Rule restricted informing the patient about her full condition and was considered malpractice. In 1993, President Clinton issued an executive memorandum that suspended the Gag Rule until present day (National Partnership for Women and Families, 2008).

The Gag Rule imposed an unethical medical practice violating the standards of care in family planning clinics. Additionally, it restricted women's rights and negatively impacted their overall health care. By preventing women from knowing all available healthcare options, the Gag Rule disempowered them. This disempowerment at a governmental level trickled down to the disempowerment of females at an individual level, both at work and at home. Here, I speculate that adolescents witnessed this dissolution of personal power; they potentially translated this disempowerment into how they developed their own romantic relationships.

*RU 486*

Thus far, abortion has only been discussed in terms of a surgical abortion needing to take place in a medical clinic. However, in recent years, a new method of abortion came into existence which inspired more political discussion regarding pregnancy management. RU 486 (also known as Mifeprex or mifepristone) was approved by the FDA in September of 2000 as a chemical abortifactant. The medication had been approved for use in France in 1988. The FDA, generally being more vigilant about testing drugs than other westernized countries, delayed approval by more than a decade and placed strict procedural rules on dispensing the drug. In the US, the drug can only be dispensed by someone who has surgical privileges (United States Department of Health and Human Services., 2000). This dispensing restriction means there are a limited number of providers to prescribe the medication. However, the number grew from 88 providers in 2001 to 202 providers in 2005. The drug manufacturer, Danco, reports that more than 840,000 US females have used mifepristone since it was approved. The oral medication allows an abortion to take place in a more private setting than in a healthcare clinic. It generally costs around $100 more than a surgical abortion, which might be a result of the required second office visit (Stein, 2008). In 2006, about 156,000 (13%) of the 1.2 million abortions in the United States were done with RU 486 (Guttmacher Institute, 2008a).

In Oklahoma, 714 (11%) of the 6,595 abortions were done with medication in 2006, suggesting an incidence slightly lower than national statistics. In Oklahoma, an abortion clinic manager stated that 99% of their abortions were done surgically (Burns, personal communication, July 15, 2008). Requirements for a chemical abortion include

previous childbirth and residence in the immediate area. The FDA requirements state that the prescribing physician must also have surgical privileges to treat any side effects. For this reason, the patients must live in close proximity of the prescribing physician. The cost of a medicinal abortion in Oklahoma is identical to that of a surgical abortion.

*Partial Birth Abortion*

In November of 2003, Congress passed the Partial Birth Abortion Ban Act, which was designed to reduce access to second-trimester abortions, and defined the physicians who performed second trimester abortions as criminals. The law has produced fear in physicians as it was written in very vague and inaccurate medical language. The intent of the law was to intimidate medical providers with the constant threat of criminal charges and to frighten the medical community (Blumenthal, 2003). The law fails to consider that healthcare providers understand the environment in which females and/or parents are called upon to discuss the difficult decisions surrounding the health conditions that may require a second-term abortion. Examples of these situations include medical conditions of the mother who may not survive a pregnancy and/or genetic conditions of the fetus that are not conducive to life. Other medical situations, not outlined in the law, are surgical conditions where a surgeon may need to modify his/her procedure in the best interest of the patient. The Partial Birth Abortion Act would curtail the types of surgery that may be necessary in specific health emergencies (a mother's life is at risk) since the procedure is defined as criminal.

Healthcare providers objected to this law for additional reasons. It allows the government to legislate what type of surgery a doctor performs regardless of the medical situation of the patient. This violates the time-honored, peer-review standards

established within the medical community which does not keep the interest of the patient at the center of the health care. While the lack of patient-focus was problematic in and of itself, the law created additional concerns for practitioners. Instead of simply fearing the governmental repercussions of the law, the legislation allowed relatives of the patient to sue a physician for unlimited monetary damages by alleging that an illegal abortion was performed (Blumenthal, 2003). Hence, the medical provider could be vulnerable to malpractice suits as a result of family disputes.

This law reinforced Congress and the Court's blatant disregard for the health of pregnant females in opposition to the expertise and judgment of the medical profession (Annas, 2007). Opponents of the law questioned its true intent: Was it intended to ban a procedure described as gruesome and inhumane, or was it a calculated step toward a ban on surgical abortion (Greene, 2007)? The restrictions of the Partial Birth Abortion Act has altered the way physicians provide services to pregnant women in life threatening situations, compromising the quality of care.

*Emergency Contraception*

Emergency contraception (EC), also known as the morning-after pill, is a safe form of contraception used up to 72 hours after unprotected intercourse to prevent pregnancy (Erdahl & Holten, 2006; Xu, Vahratian, Patel, McRee, & Ransom, 2007). EC was approved as safe by the FDA in 1997 and was a prescription drug dispensed by healthcare providers. In 2006, the FDA approved EC for over-the-counter purchase by females 18 years or older upon signing a document stating the pill is for their use. Despite its accessibility, it still remains a vastly under-used method (Xu, et al., 2007).

EC is used after unprotected intercourse, including condom breakage, missed birth control pills, intercourse without any protective method, or in the case of rape or incest. EC is most effective in preventing pregnancy if taken as soon as possible after intercourse, but has some effectiveness for as long as five days after unprotected intercourse (Xu, et al., 2007). Females and health providers alike often confuse the action of EC, which contains the same chemical that is in birth control pills, with RU 486, which is a pill used to produce a medical abortion after pregnancy is established.

Many females still do not know that EC is a safe and effective method of contraception and is not an abortion. Healthcare providers must play a role in educating females about the safety and availability of this option. Some medical personnel do not provide this information to females because they feel EC would decrease the use of routine contraception and promote promiscuity (Xu, et al., 2007). When healthcare providers withhold information from their clients, such as the function and availability of EC, they compromise the clients' right to choose. While this lack of information impacts females of all ages, it is especially problematic for those under the age of 18. The age limit placed on the over-the-counter access to the medicine restricts adolescent females' right to choose and does not help them prevent unwanted pregnancies. Women and adolescents, who are unaware of emergency contraception, are more likely to have an unintended pregnancy. Statistics show that unintended pregnancies are most likely to occur in the young, the unmarried, the low income, and the uninsured (Goldsmith, Kasehagen, Rosenberg, Sandoval, & Lapidus, 2008).

*Parental Consent*

Many adolescent females need reproductive health care, but can only access the services for abortion, RU 486, and EC with the approval of their parents. Ironically, in the past 20 years, as the number of sexually explicit images bombarding our youth has increased, the laws for parental consent for an unemancipated minor have become more restrictive. The effect of this conservatism provides more restrictive health care for minors and more severe punitive consequences to healthcare providers who violate the law.

As a woman's healthcare provider for more than 20 years, I have personal experience delivering reproductive health care to adolescents. I have experienced how conservative legislation restricts the delivery of health care to adolescents who are frequently in compromised conditions. The minors who are most in need of health care and seek healthcare services without parental consent frequently arrive for services without family support. These are the minors who are most affected by the restrictive laws. Punitive action against healthcare providers who deliver care without parental consent has become so severe that healthcare providers are more inclined to abandon the needs of the minor, when their legal status and medical careers could be jeopardized. Medical organizations, local and national, usually fight legislation that compromises medical practice and/or the doctor-patient relationship. However, when minors are the target of the legislation, it seems that no one is willing to take on the battle.

The laws which have been discussed up to this point have primarily addressed women's reproductive rights at the national level. Many of the laws restricting the

medical care minors receive have been enacted at the state level. Since the participants in this study were all residents of Oklahoma, a brief history of the relevant Oklahoma legislation that has affected reproductive health care for minors will be discussed.

In January of 1986, the Attorney General of Oklahoma was asked to render an opinion regarding the need for parental consent to treat minors in programs funded by Title X. After reviewing several rulings by other states denying Title X services to minors without parental consent for treatment, he ruled that the intent of Title X programs did not exclude the treatment to minors. Further, he said if the state imposed the need for parental consent for minors to receive these services, the state would be in violation of the intent of the original program. This ruling by the Attorney General protected minors' rights to receive reproductive health care (Attorney General Opinion, 1986).

Oklahoma does not use any federal or state monies for abortion services. Due to the lack of state and federal monies, Oklahoma mandated that it was illegal to provide abortion services to minors without parental consent in November of 2006. Violation of this law was a misdemeanor for healthcare providers ("Illegal Abortion on Unemancipated Minor - Criminal and Civil Liability. 49th Okla. Leg.," 2006). The punitive action was increased to a felony offense in November of 2007 ("Illegal Abortion on Unemancipated Minor - Criminal and Civil Liability. 50th Okla. Leg.," 2007). This law does provide very limited access to abortion for minors lacking parental consent. The minor must appeal to the court system for judicial authorization for the abortion. When one considers the action needed to navigate the court system, the need for an attorney, the lack of family support, and the time limit required for first trimester

abortions, soliciting the court is an overwhelming task for a minor. Hence, a court appeal as an alternative route for a minor to get an abortion without parental consent is not really viable.

In 2006, SB 1742 was passed into law requiring all females requesting an abortion at 20-weeks gestation or greater, to be informed by their healthcare provider that her unborn fetus(es) may experience pain and that anesthesia could be administered to the fetus. They also must be offered the option of seeing an ultrasound sonogram of the fetus prior to undergoing the abortion. The same bill imposing these interventions on medical care to females made provisions to allocate state funds to organizations providing anti-abortion counseling (SB 1742, 2006). In April 2008, the law was made more restrictive by requiring an ultrasound prior to performing an abortion. The physician is required to verbally describe, in detail, the findings of the ultrasound. The ultrasound must be performed with a vaginal probe, although an abdominal receiver may be more effective (Stone, 2008). On October 9, 2008, a legal advocacy group filed a legal challenge to this law claiming that it violates privacy, endangers health, and assaults the patient's dignity (The Associated Press, 2008). The results of this legal action are pending.

Oklahoma laws continue to become more restrictive of the rights of both adult females and minors. A former Oklahoma legislator, when asked her opinion regarding what issues she thought most influenced the reproductive health issues in Oklahoma, identifies three major reasons for restrictive legislation in the state. First, Oklahoma ranks approximately 47$^{th}$ in the nation in the number of women in the legislature. Second, the culture of Oklahoma is very individualistic with residents looking to their

own families or church leaders for direction. This cultural orientation would stifle access to sex education and makes discussion of reproductive health nearly nonexistent. Third, the strongest legislative lobbyists represent insurance companies that are more inclined to restrict females' reproductive rights.

Despite the heavy restrictions on a minor's access to abortion, a minor does have some access to birth control in Oklahoma without parental consent. There is no age restriction on purchasing condoms over-the-counter and healthcare providers can prescribe other forms of contraception without parental consent. These limited contraceptive options for minors still come with monetary and insurance restrictions. Since many adolescents attend school, they have limited time to earn their own income to purchase contraceptives. In regard to oral contraception, the cost is often too prohibitive for purchase without insurance. Additionally, since many adolescents use their parents' health insurance, they cannot fill a prescription without sacrificing their privacy.

The issue of health insurance limits the reproductive choices of adolescents and adult women. The literature is clear that females without health insurance are less likely to use the most effective contraception that requires a prescription (Culwell & Feinglass, 2007a; Kuhn, 2007; La Plante, 2006), which places these females at an even higher risk for unwanted pregnancies. State Legislators attempted to aid access to contraceptives by instituting state mandates requiring private insurers to cover their costs. The mandates were effective as the use of prescription contraception increased between the years of 1995-2002 (Culwell & Feinglass, 2007b).

Oklahoma residents did not experience the same increase in coverage as the state does not mandate prescription contraceptive drugs and devices for all private insurance. In fact, the only mandate is for partial coverage by health maintenance organizations (HMOs) (Guttmacher Institute, 2008c). Compounding the problem of lack of contraceptive coverage for insured residents is the number of uninsured residents. In 2006, 19% of Oklahoma's residents were uninsured (La Plante, 2006), compared to 15.8% nationally (United States Census Bureau, 2007). Without private or public health insurance, females are 30% less likely to use medically-prescribed contraception (Culwell & Feinglass, 2007a). When we seek to reduce the number of unintended pregnancies, we need to improve access to contraception that would assist all females of reproductive age.

If it were possible to give all females access to birth control and information about how to use it effectively, then the abortion rate would be greatly reduced. As previously discussed, on the surface, it appears that females have been granted the power to choose how to handle their pregnancies through the Supreme Court decision *Roe v. Wade*. Once one examines the complex state court legislative rulings about medicinal abortions, partial abortions, emergency contraception, and their implications for adolescents, these freedoms are greatly restricted. Government restrictions on women's healthcare options reduce the opportunities for managing reproductive issues. The message construed from these restrictions can subconsciously undermine women and adolescents' perceived power in romantic relationships and in expressing their sexuality.

## Development of Well-Women Health Care

Thus far, the discussion of power over health care has been addressed only from the perspective of preventing and managing pregnancies. However, females have many more sex-specific healthcare issues that impact their lives. Two of these issues are cervical cancer and breast cancer. Through the advancement of science over the past century, research has shown that mortality rates for these diseases can be decreased with early detection through early screening. Unfortunately, as is the case with contraception, not all females have the same access to the best health care, and many do not receive early screening. Several healthcare organizations have tried to overcome this hurdle by standardizing the well-women checkup and even offering free clinics throughout the country.

Since the 1940s, a common procedure in most well-women annual checkups (including for adolescents) is the Pap smear (Bryder, 2008). The Papanicolaou (Pap) smear is a screening test for abnormal cervical cells that identifies actual or preneoplastic cervical cell changes. Screening provides early detection and treatment, thereby eliminating the detrimental effects of untreated cervical cancer (Younkin, 1998). In the 1940s, cervical cancer was one of the leading causes of cancer death in women, but it now ranks 14$^{th}$ due to early detection (National Cancer Institute, 2008).

The effective screening and treatment of cervical cancer or dysplasia differs for adolescents and adult women. Adolescents need conservative treatment in order to avoid compromising their ability to conceive and sustain a pregnancy. Furthermore, parental consent may be required for aspects of their treatment. Legally, adolescents can consent to medical treatment for STDs and contraception without parental involvement.

While obtaining these services, a routine Pap smear is usually collected. If there is an abnormal pap result that warrants further treatment, parental consent is needed for the treatment. This creates a complex situation for the adolescent and the healthcare provider if the parents were uninformed of the initial diagnosis (American College of Obstetricians-Gynecologists, 2006).

In addition to reducing the mortality from cervical cancer through routine screenings, scientists developed a vaccine to prevent several strains of the Human Papaloma Virus (HPV), a leading cause of cervical cancer. Females between the ages of 11 and 26 have been targeted to receive the vaccine (Centers for Disease Control and Prevention, 2008a), which was approved by the FDA in June of 2006 (National Cancer Institute, 2008). Although the long-term outcome of the vaccination is unclear, a national campaign has been undertaken to vaccinate all young girls, ages 10-12, prior to beginning sexually activity (Adams, Jasani, & Fiander, 2007). Oklahoma joined this movement when the 2007-2008 Oklahoma Legislature successfully passed Senate Bill 1522 (S. 1522, 2008). This law mandates that all parents of sixth grade girls provide the school district a written statement regarding their daughter's vaccination status. If parents choose not to have their daughter immunized, they must submit written documentation indicating that they chose not to disclose their immunization status. Given the ages of most of my research participants, the HPV vaccine has not been approved when they were early adolescents. However, I mentioned the vaccine because it will be an important public health issue for future generations of adolescents and parents. Further research is needed to determine the individual and social effects of the vaccine on adolescent romantic decision-making.

The second common procedure for women and adolescents in well-women exams is breast exams. Breast cancer is the most commonly diagnosed cancer in females. The national incidence of breast cancer is 117 per 100,000 and in Oklahoma, it is 125 per 100,000 (Centers for Disease Control and Protection, 2008). Similar to cervical cancer, there is a better prognosis when the cancer is detected early (Coburn, et al., 2008). In healthcare clinics, breast exams are usually performed to detect lumps and other abnormalities. If the exams produce any concern, then mammograms are ordered. The standards of care dictate for women over 40, than an annual mammogram, are performed. Additionally, for females at high risk of breast cancer due to genetic predispositions, mammograms are performed at earlier ages (National Cancer Institute, 2007). Mammograms are rarely performed on adolescent females unless a problem arises.

Women from lower SES neighborhoods, non-whites, and the uninsured receive a lower percentage of recommended mammograms. Thus, they seek health care when the disease has progressed to more advanced stages with increasing mortality rates (Coburn, et al., 2008). The Breast and Cervical Cancer Mortality Prevention Act of 1991 established a nationwide, comprehensive public health program to increase access to breast and cervical cancer screening services for underserved women (Henson, Wyatt, & Lee, 1996). In January of 2005, Oklahoma Care, in conjunction with other state organizations, offered services for breast and cervical cancer diagnosis and treatment to women under 65 who qualified for Medicaid (Oklahoma State Department of Health, 2008). Generally speaking, adolescent females have a lower likelihood of developing breast cancer, which impacts the type of screening they receive. Since basic

screenings are a part of the standard well-woman check, adolescents are exposed to breast health issues, an important part of their sexual development. However, since breast health does not relate to STDs or pregnancies, this study did not specifically address it as a factor in adolescent decision-making in romantic relationships.

## Summary

The history of female reproductive health at the local and national levels established the sociopolitical context in which my research participants make decisions about their romantic behavior. In 1965, the US Supreme Court upheld a woman's fundamental right to privacy, including freedom to use birth control. Yet, more than 40 years later, the battle to gain access to prescription contraception continues (Kuhn, 2007). Income, race, and insurance access all prove to be barriers to obtaining contraception despite the government's attempts to providing equal access to health care to all females. While the laws surrounding contraceptive rights are somewhat less restrictive than they were 40 years ago, the development of restrictive legislation, the battles over insurance coverage, emergency contraception, abortion, and parental consent for minors' health care generate heated debate in courtrooms, churches, and homes.

The participants in this study were not old enough to recall the days of illegal contraception, but they have been in the middle of the debates about the other reproductive health issues. Additionally, they have mothers, grandmothers, and aunts who do remember more restrictive birth control access. These women grew up in a time when the government exercised more control over female sexuality, which greatly impacted their perceptions of power within romantic relationships. As discussed in the

literature review, the influence of strong females (particularly mothers) on growing adolescents is profound. Hence, reproductive restrictions, experienced by mothers and older women probably influenced the sex education they provided to female adolescents including the participants in this study.

For many years and in many parts of world, females have battled for equal rights, equal representation, and equal pay. At the heart of all of these issues rests the fundamental right for females to choose the course of their own health care. As federal and state administrations change over time, women's reproductive health issues are revisited. Hopefully, old and young females develop an accurate history of the restrictions on women's reproductive health and make efforts to prevent history from repeating itself.

# CHAPTER IV – METHODOLOGY

Large organizations, such as the National Institute of Child Health and Human Development (2007) and the World Health Organization (2004), have conducted national and international surveys assessing adolescent sexuality and risky sexual behaviors. Many other research programs have also attempted to analyze risky sexual behaviors of adolescents using quantitative studies. Through multivariate analyses, researchers have tried to establish the inner relationships among variables including, but not limited to, race, family situation, and age at first intercourse, STDs, and the frequency of becoming a pregnant teen. While these types of quantitative research methods inform researchers about statistical relationships between variables, they fail to explain the comprehensive situation of how the variables interrelate (Lofland & Lofland, 1995; Spradley & McCurdy, 1988). This dissertation attempts to fill in the gaps in the literature resulting from the limitations of quantitative data gathering and analysis in favor of ethnographic methods, including in-depth interviews. The value in comparing results from both quantitative and qualitative methods is derived from the complementarities in utilizing both methods to validate or refute findings (Singleton & Straits, 2005).

The ethnographic interview is a qualitative research method which is used to capture an all-encompassing picture of the participants and their unique situations. Qualitative research methods gather data in the form of text, pictures, or objects. Then, the researcher analyzes the data to find important themes or messages as explained by the participants. One important characteristic of qualitative methods is that they allow the participants to communicate the important themes to the researcher as opposed to

the researcher identifying the themes for the participant (Spradley & McCurdy, 1988). Qualitative research methods are very labor intensive in both the data gathering and analysis, which results in smaller sample sizes. This method avails to comparability and translatability of findings, rather than generalization to larger populations (LeCompte, 1982).

Unlike qualitative methodologies, quantitative methodologies use surveys and questionnaires that are more adaptable to a larger sample size. The data from these methods are reducible to numbers which allow the researcher to use relatively quick statistical analysis to find relationships among variables. Gathering and analyzing the data takes considerably less time than qualitative research methodologies and is often generalized to larger populations. However, the use of surveys and questionnaires to explore romantic behavior can force participants to respond to limited options which do not adequately describe or explain their personal situations. Significant variables about adolescent sexuality may be omitted from the study since the researcher, as opposed to the participant, identifies the data that was important to gather. Additionally, coding and standardizing responses based on deficient or misleading data paints an incomplete, if not inaccurate, picture of the data (Marshall & Rossman, 1980).

Qualitative research interviews provide an opportunity to delve into and explore subjective meanings that quantitative research often strips away in an effort to elicit standardized responses. The interviewer looks to the interviewee for subtle meanings, confusion about questions, ambivalent feelings, and/or strongly held beliefs that make the research so rich and interesting (O'Reilly, 2005). It is this type of data that is needed to provide a more complete understanding of how previous quantitative studies identify

and explain issues regarding adolescent sexuality. While quantitative assessments address the what, where, when, and frequency of occurrence of a problem, qualitative methods also explore the why and how of a problem (Lofland & Lofland, 1995; Spradley & McCurdy, 1988).

By using feminist, qualitative methods, this dissertation aims to provide greater insight into the existing quantitative analyses about adolescent sexual development. These methods are appropriate to direct the development of culturally-sensitive theories, culturally-appropriate research tools, and patient-centered, tailored interventions that are effective, feasible, and acceptable to users (Sandelowski, 2004). The feminist perspective is being employed in order to explore adolescents' views of their own reality (Reinharz & Davidman, 1992). By creating a supportive atmosphere focused on the health of females, the participants interviewed have been given a voice to articulate their experiences about grappling with the developmental challenges of sexual identity.

This study has employed non-experimental, ethnographic interviews using a variety of methodologies including genograms, observation, and case study. All methods contribute to the analysis of positive and negative aspects of adolescent romantic relationships from psychological, social, and cultural perspectives. Due to the limited amount of qualitative data exploring adolescent romantic relationships, I believed that semi-structured, open-ended interviews would provide the richest data viewed through a holistic lens. Additionally, ethnographic interviews allow the researcher and participant to discuss the meaning of questions and responses to avoid making invalid presumptions about the data, thus providing a high degree of validity.

Each interview began by obtaining a family history of the participant. In order to save time and increase accuracy, I collaborated with the participant to draw a genogram of her family. Participants oversaw the drawings for accuracy which stimulated conversation about the complexity of their families as well as the significance they assigned to various family members. After the family history was completed, the participants became the teachers as they described various aspects of their lives related to family, school, and peers in order to paint a picture of their adolescent development. The participants related their own adolescent experiences. The interviews concluded with the researcher asking how each participant thought her younger sister(s) (or younger adolescent females in general) could be better prepared for adolescent romantic relationships. Throughout the entire interview, I collected ideas, thoughts, and nonverbal cues about the subject matter from each participant, which could not have been accomplished with quantitative methods.

## Study Population

Twenty-eight participants between the ages of 19 and 29 were selected for this study. Minors were not asked to participate due to the sensitive subject matter and the need for parental consent, which would have made IRB approval very difficult, if not impossible, to obtain. Also due to IRB restrictions, the topic of abortion was not included in the interview questionnaire. If a participant had mentioned abortion as a part of her sexual development, then it would have been explored. However, no participant implied or directly stated that she had had an abortion.

All of the participants were from the Oklahoma City or Tulsa metropolitan areas. In order to take part in the study, a participant had to be female, between the ages

of 18 and 35, and a resident of Oklahoma. Although the sexual orientation of the participants was not restricted, all participants were heterosexual. Nursing and pre-nursing students at the University of Oklahoma were excluded from the study to avoid the possibility that they might become future students of the interviewer. In the acquisition of participants, race was a qualifying criterion which will be discussed in more detail later in this chapter. Ten Euro-Americans, six African-Americans (one of whom was a daughter of Ethiopian parents), six Latinas (Mexicans with one exception, the daughter of Guatemalan parents), and six American Indians were selected to be interviewed. While this distribution does not match the national or state population distributions, it was believed that having equal proportions of minorities was needed in order to compare developmental variables.

Participants were recruited through fliers posted in highly trafficked areas at Planned Parenthood locations and the Oklahoma City Indian Clinic. Additionally, the snowball approach was utilized. After each participant completed the study, she was asked to recruit her friends to take part in the study. One participant went so far as to post the study recruitment form and my contact phone number on her Facebook page, which generated several phone calls. Finally, friends of the researcher were asked to recruit their friends to take part in the study.

When a potential participant called, I explained that I would be the interviewer and that I was a women's healthcare practitioner, educator, and doctoral student. I described my experiences working with young women in healthcare clinics who dealt with the problems of unwanted pregnancies and sexually transmitted diseases. I further explained that the study explored the positive and negative aspects of romantic

relationships of adolescent females in order to obtain data that could better inform educators and healthcare providers about their needs. Additionally, the caller was told that a $20 stipend was available to partially compensate interviewees for their time and travel costs, if they chose to participate. If the caller was interested in participating in the study, the interviewee and I arranged to meet at a mutually agreeable time and location that was conducive to private conversation. The potential participant was assured that her identity would be held confidential in the study and protected through measures approved by the IRB.

## Conducting the Interviews

The use of semi-structured, face-to-face interviews has become the principal means by which feminists have sought to achieve the active involvement of respondents in the construction of data about their lives. These semi-structured, or open-ended, interviews explore people's views of reality and allow the researcher to generate theory as interviewees share their ideas, thoughts, and memories in their own words rather than the words of the researcher (Reinharz & Davidman, 1992). This type of methodology permits unobtrusive observations about the interviewee which can help inform the researcher. While this method is more time consuming for the interviewee and interviewer, it is the oldest and most reliable qualitative research method (Singleton & Straits, 2005).

In order to guide the interviewees, I developed and tested a list of open-ended questions in 2006. Five American Indian women, between the ages of 18 and 38, were interviewed. The questions were constructed after a thorough literature review to determine whether the questions properly guided the participants to discuss the desired

topics. The results required minimal revisions. The findings stimulated the desire to include African-Americans, Latinas, and Euro-Americans due to the general lack of qualitative data about these racial groups. It was believed that the dissertation could not only provide data about the needs of American Indians but also the needs of young females of other races. The resulting benefit of increasing the number of participants was the ability to compare and contrast the experiences and needs of adolescent females across cultures.

After analyzing the test study participants' responses, I made only minor adjustments to the interview questions due to the high quality of the participant's responses. The final version of questions included topics that explored the following: family composition, school performance and extracurricular activities, peer group participation, individuals with whom romantic relationships were discussed, the construction of an ideal romantic relationship, role models, and lastly, their advice to younger females about adolescent romantic relationships (Appendix B for a complete copy of the questionnaire).

Before beginning each interview, I gave the participant a list of the interview questions along with the IRB consent form and the audio-recording consent form. Once the consent form was discussed and signed, the interview began.

I constructed a genogram by asking the participant to outline three to four generations of her family. The genogram served two purposes. First, it provided basic demographic data about the participant and her family of origin. Charting the participants' genealogies provided a unique record to compare and contrast similarities and differences between and among individuals and cultural groups (Reinharz &

Davidman, 1992). Second, it served as a means for the participant to begin to trust the interviewer and the interview setting. Creating a trusting relationship was important for establishing an atmosphere in which the interviewee felt safe in disclosing personal information and engaging in an exploration of how she constructed meaning about romantic relationships (Reinharz & Davidman, 1992).

After creating the genogram, the list of questions was used as a guide to direct the path of the interview. My questions were arranged so that they progressed from general to more intimate in order to build trust in the interviewer and interviewee relationship. Interviewees had ample time to explore the questions and answer them in whatever way they felt was most reflective of their past experiences. Research notes were taken during the interviews. Additionally, they were also audio-recorded for professional transcription. Despite the long list of open-ended questions, each interview was restricted to approximately one hour in an effort to be mindful of the agreed upon time commitment. At the end of each interview, the participants were given the $20 stipend and asked if they could be contacted for follow-up questions. All participants completed the interviews in full even though not every question was answered in full. The length of a response for one topic led to an adjustment in the available time for other questions. While this did result in some missing data, the participants were allowed more openness in their responses to questions that were of particular interest.

## Participant Variability

There was a wide range of variability in the experiences communicated in the participants' stories. I sought interviewees with varied backgrounds to enhance the range of experiences they had in their journey through adolescent development.

Although all participants were upwardly mobile and represented the ideology of the middle class, their experiences were vastly different. The following two cases of women who were the same age exemplify the extreme variation in individual and cultural situations.

My first example is of a young Latina who was raised by her grandmother in a stable environment. She lost that stability when her mother arrived from Mexico and assumed her care. The mother was single and unable to provide the supervision and support previously provided by the grandmother. The young woman returned to Mexico where adult supervision was vastly reduced. In addition, she experienced the loss of her peer group and became romantically involved with a much older man. The story represents a complex turn of events that resulted from lack of support and supervision in her early adolescent years. The second example is a young Euro-American woman who was raised by both parents. She was provided information and emotional support about reproductive health. Throughout her development, she was encouraged to make good relationship choices. She also participated in a peer group. The stories of these two young women continued along divergent paths as indicated below.

Linda, a 22-year-old Latina participant, describes her story of becoming romantically involved. She was raised by her grandparents prior to attending junior high school. Her mother was in Mexico while her grandmother raised her. When Linda was in junior high, her mother arrived in the US and assumed the care of her daughter. Linda stated that her mother did not know how to raise her as well as her grandmother did. Prior to junior high, Linda loved school and her grades were very good. After moving in with her mother, Linda started getting into fights at school. In response to an altercation,

she keyed someone's car. Her mother was held responsible for the damages of $800. The mother could not pay the fine and in order to avoid legal action, she chose to flee to Mexico with her daughter. In Linda's new surroundings, at the age of 14, she felt very isolated without her grandmother and school friends. Linda began to date a man who was 27-years-old. She said she enjoyed his company. He gave Linda a feeling of security and safety. She stated that in the beginning of the relationship he didn't pressure her to have sex. Eventually he threatened to leave the relationship if she didn't have sex with him. Therefore, Linda succumbed to his pressure to have sex. She told her mother when she lost her virginity. Although Linda knew that her mother would be angry, she thought that she would be a bit understanding because her mother had become a teen mother at the age of 13. Linda's mother was saddened by her daughter's sexual involvement and assumed that once she participated in sexual activity it was highly unlikely that she would stop.

Linda's mother offered to get her daughter birth control but she declined the offer because she didn't believe she could get pregnant. Linda had no formal sex education classes and neither her grandmother nor her mother ever taught her about reproduction. Linda was, therefore, totally naïve about reproduction. Her grandmother had strongly instructed her to avoid a man's touch in her private areas. Linda had to tell her grandmother if anyone tried to touch her. She stated that in hindsight, this was her grandmother's way of protecting her from sexual advances at the age of 12. Four months after she started having intercourse, she became pregnant. She moved back to the US to have her baby, but after its birth, returned to Mexico and subsequently got pregnant again by the same man. Linda returned to the US to have her second baby, but

remained with her grandmother. Linda's grandmother told her she needed to be responsible for her babies and advised her to be selective about romantic involvement. She stressed that it would be better for Linda to wait until she found a good man. If she was going to have sex, she needed to use protection. Linda was encouraged to find a job and focus on her children until she could meet a man that would treat her with respect and was willing to help her take care of her children. Linda focused on her children and took on the responsibility of raising them. She is currently living with the man who fathered her third child. He has a good income and is a father figure to all her children. Linda credits her grandmother's advice and support with helping her to obtain a very good and stable life.

It is easy to understand that the circumstances involved in this young teenager's life were conducive to her becoming pregnancy. Under the care of her grandmother, Linda excelled in school and was emotionally supported by loving adults. When the circumstances changed and most of her support systems were removed, Linda's education ceased, she lost the support of her grandmother and peers, and became vulnerable to the advances of an older man, thus resulting in not one, but two, teenage pregnancies. It is remarkable that even with the burdens of teen parenthood, when Linda returned to live with her grandmother, she was able to focus on her children and make a home for her family.

In the second case study, Karney a 22-year-old Euro-American, was raised by both parents. Although her father was an alcoholic, her parents stayed together and remained committed to the family throughout his recovery from addiction. The children were always supported even during brief times of the father's absence in recovery. Her

mother took the leading role in educating the children about reproduction and decision-making related to relationships. Karney was the middle child in the family and did not think her sisters internalized her mother's guidance as well as she did. Karney's oldest sister is in her second marriage and her younger sister has repeatedly made poor relationship choices. She described her mother as a nurse who always talked openly to her and her sisters about reproduction and relationships. When Karney was five or six years old, she remembered her mother telling her about the "birds and the bees" and revisiting the conversation when she was very close to puberty. Information about anatomy, physiology, and the emotional component of sexuality were discussed. Karney's mother told her that she did not need to wait until she was married to have sex, but that she should choose someone who respected her because it would be something that she would remember for the rest of her life. In addition to reproduction, Karney's mother used other opportunities to tell her daughters that women should not accept unacceptable behavior from men. Her mother used examples of abusive situations occurring with her personal friends and on TV. She emphasized to her daughters that females do not have to accept abusive behavior.

Karney remembered becoming interested in boys and beginning to kiss and pet around the age of 13. She initiated first intercourse at the age of 15. She talked to her friends about it, but did not tell her mother. About a year after Karney's first sexual encounter, her mother asked her if she needed to start using birth control, which she did. Karney thinks her mother would have been very open to discussing her relationships, but that she did not really want to share all the information for two reasons. First, Karney was embarrassed; and, second, she did not want to receive advice or feel judged

concerning her romantic involvement. As she reflected on her adolescence, she felt positive about her choices. Although Karney initiated sexual activity with someone who was "not that great," she did not have any regrets about the relationship. Karney credited her mother with providing information that kept her from having a lot of heartache and from getting pregnant. At the time of this interview, Karney was in college and involved in a different relationship. She was looking forward to getting married and having children someday. However, she thought it was very important to prepare her to take care of her children and provide them with the same opportunities that her mother and father provided for her.

Although Linda and Karney entered into romantic relationships at approximately the same age, the outcomes of these relationships were vastly different. I found contrast among several participants, even from small geographic areas. Race, socioeconomic level, family support, and peer group involvement are factors influencing individual circumstances and decision-making processes.

## Limitations

Despite careful planning, the methods used in this study did create some limitations. First, snowball sampling method, a referral sampling technique, does not allow random sampling. While random sampling is often considered ideal for scientific purposes, it was not feasible for this study due to its subject matter (Singleton & Straits, 2005). Although snowball sampling can provide a nominally defined sample, the limitation was counter-balanced by the benefits of the method. For example, snowball sampling allowed the establishment of trust between participant and researcher. As friends told their friends that I was not threatening or embarrassing, more young women

were inclined to actively participate in the study. Establishing this trust was important for two reasons. First, trust was needed to encourage the depth of disclosure necessary for exploration of sensitive aspects of one's life history. Second, rapid development of trust was needed to cover the entire interview protocol in a one-hour interview. Even though snowball sampling can create a homogenous sample, my study participants had widely varying backgrounds. However, there was a demographic difference in the racial groups with Euro-Americans all being full-time students or having college degrees. Minorities were generally college bound, working full-time, and raising children after failed marriages and relationships.

A second limitation to the study centered on the absence of abortion. As previously mentioned, the topic of abortion was not specifically addressed in the questionnaire. Due to its sensitive nature, it would have required additional IRB-approved participant protection. Also, I thought that the participants would be more reluctant to participate if they had previously had an abortion. Studies have shown that participants frequently do not disclose their status about past abortions (Chavkin, 2001).

Third, the participants were asked to reflect on their adolescence. Interview data collected retrospectively has been found to be less accurate than data collected immediately. Retrospective data, although it lacks accuracy for specific dates and frequency of events, is more accurate in recalling general events, which helped me to discern decision-making processes (Bill, Moffitt, Caspi, Langley, & Silva, 1994). The accuracy of retrospective recall can be improved by the use of memory probes and cues that also take into account cultural differences (Hatch, Von Ehrenstein, Wolff, K. Greduld, & Einhorn, 1999; Martyn & Belli, 2002). Constructing the genogram helped

the participants recall important people in their lives during adolescence and specific situations and events they encountered. Additionally, the open-ended questions allowed the individuals to apply each interview question to their past, which helped me prod their memories.

Fourth, interviews were restricted to one hour. This in combination with the semi-structured format of the interviews, led to some data not being elicited. On my initial phone call asking the participants to take part in the study, they were told that the interviews would last approximately one hour. In order to gain their trust so that they would refer me to their friends, I deemed it important to stay within the original timeframe. In addition to these four limitations specific to this study, the general limitations of qualitative studies that were previously mentioned at the beginning of Chapter IV are also applicable. However, as discussed, significant efforts were made to minimize the impact of all of these limitations in my data analysis and conclusions.

## Data Analysis

Due to the quantity of data obtained in each interview, the data analysis was labor-intensive. Each interview had four sources of data associated with it: the interviewer's note, the genogram, the professionally transcribed transcript, and the audio-recording. In following the guidelines of qualitative data analysis, I coded the data to identify general themes and did some quantification of these themes in individual cases. Three coders, trained in qualitative methodology, reviewed 10% of the transcripts to examine existing themes and contribute new ones. The transcripts were discussed and compared until consensus about the themes was identified among the coders. When themes were finalized, I coded the remaining data. In order to manage the

vast amount of data, I used NVivo, a qualitative analysis computer software package (Gibbs, 2002).

In addition to analyzing the transcripts, audio-recordings were played and replayed to reconstruct the emotional aspects of each interview. The data were used to explain the emerging themes. When the transcripts or recordings presented confusion, the genograms and interview notes were referenced for clarification. My findings will be presented in Chapter V, “Findings and Analysis.”

# CHAPTER V – ANALYSIS OF FINDINGS

Since the interviews were an important component of my dissertation research, I will focus on the analysis of my open-ended questions in this chapter. I will consider the interviewees' relationships with members of their nuclear families, extended families, and, in some instances, blended families with regard to shaping approaches to adolescent sexuality and romantic involvement. I will also consider a variety of demographic issues in enumerating responses for several tables in this chapter. My chapter outline includes the following: demographics (race, age, social class, education, marital status, and number of children), family composition, relationship to peers, reproduction education, construction of ideal romantic relationships, first relationship and/or loss virginity, and interviewees' advice to adolescent girls about romantic relationships. The discussion follows the interview format used with participants, rather than that of the literature review.

## Demographics

Of the 28 participants, there were 10 Euro-Americans, 6 African-Americans, 6 Latinas, and 6 American Indians. All participants were between the ages of 19 and 29, with the average age of 24. Each participant represented the upper-working or middle class and had middle class aspiration. The definition of middle class for this study is the middle of the social strata including those who are college educated and the upwardly mobile working class. A majority (22), of the participants had attended college, and 3 had plans to attend in the near future. If the participants were not in college at the time of the interview, they had jobs that provided the security of food, clothing, shelter, and healthcare benefits. One exception, a Latina participant, was a stay-at-home-mother

from a middle income family. However, Euro-Americans and African-Americans held more college degrees or were full-time students. The American Indian and Latina group predominantly belonged to the upwardly mobile working class with most participants working full-time and going to college part-time or with future plans to attend college.

Four of the participants were married at the time of the interview, and 5 were divorced. Eleven had children, and five of those were from teen pregnancies. The incidence of teen pregnancies is as follows: Latina 3, African-American and American Indian each one, and Euro-American zero. The number of children per participant varied across race which is shown in Table 1.

Table 1.

*Number of Participants with Children*

| Race | One Child | Two Children | Three Children |
|---|---|---|---|
| Euro-American (n=10) | 1 | 0 | 1 |
| African-American (n=6) | 1 | 1 | 0 |
| Latina (n=6) | 2 | 2 | 1 |
| American Indian (n=6) | 0 | 1 | 1 |
| Totals (N=28) | 4 | 4 | 3 |

Teen pregnancy negatively impacts educational attainment, economic outcomes, access to social and psychological resources, and health behaviors (Saegert, et al., 2006). The

five participants who experienced teen pregnancy will provide points of reference for analysis of their adolescent development, behaviors, and decision-making.

## Family Composition

To understand the structure of participants' biological and blended families during adolescence, I drew a genogram (with the participant's input) at the beginning of each interview. The genogram provided an objective diagram of the family composition, setting the stage for subjective exploration of emotionally significant relationships. This visual representation of the family tree was very helpful to understand the blended families that many participants experienced. The term biological family for this study means the immediate blood relatives of the participants, including parents and siblings. Extended family means grandparents, aunts, uncles and cousins. When parents have children from previous relationships, the children are referred to as step-siblings. Children who share one parent only are half-siblings. The latter combinations will be referred to as the blended family.

I wanted to know who the primary caregivers were in the participants' lives. The answer to the question "Who raised you?" received a variety of responses for reasons similar to Stack's (1974) research which represented family role substitutions. The participants' answers represented the complex and changing roles of parents and/or caregivers. Hence, they redirected the question to indicate with whom they primarily resided.

Table 2.

*Primary Caregiver of the Adolescent*

| Race | Mother | Both Parents | Blended Family |
|---|---|---|---|
| Euro-American (n=10) | 2 | 6 | 2 |
| African-American (n=6) | 2 | 2 | 2 |
| Latino (n=6) | 2 | 3 | 1 |
| American Indian (n=6) | 4 | 1 | 4 |
| Totals (N=28) | 10 | 12 | 10 |

As indicated in the literature review, less than half of the children in the US are raised by two biological parents (Baril, et al., 2007). My participants matched these national statistics with only 12 being raised by two biological parents. However, as Table 2 illustrates, Euro-American and Latina adolescents were more likely to grow up in a two biological-parent household than American Indian and African-Americans.

The living arrangements for three of the American Indian participants changed during their childhood. The mothers were predominately raising the adolescents until the family became blended or sustained crisis requiring assistance from other family members. None of the participants were raised by single fathers. However, one

American Indian lived with her father and his second wife for one year. Only 4 of the participants lived with grandparents for part of their childhood (two Latinas and two American Indians), and no participant considered a grandparent the sole caregiver.

Many of the participants were members of a blended family: 2 Euro-Americans, 2 African-Americans, 1 Latina, and 4 American Indians. Several participants living in blended families developed large family networks. Shared childrearing is frequently practiced in large family networks, which provides assistance to parents coping with stress involved in raising several children. The extended and blended family can serve as a way to improve the stability and collective power of the family, both financially and emotionally (Stack, 1974).

Outside of the immediate families shown in Table 2, three of my participants reported receiving assistance from their extended families early in their lives. First, Lavone, a 22-year-old Latina, lived with her grandparents in Guatemala until her parents were financially able to care for her in the US. Second, Linda, also a Latina, developed a behavioral problem and her mother sent her to live with a sister in another state. Third, Aryan, an American Indian, lived with her uncle when her mother was unable to provide for the family due to the mother's alcohol and drug abuse. The extended family provided financial and emotional support for several of my study participants when their immediate family was unavailable or unable.

The literature reveals that adolescents experience less risky sexual behavior when they are raised by both biological parents (Baril, et al., 2007; Jacobson & Crockett, 2000). In my study, none of the participants experienced teen pregnancy, an outcome of risky sexual behavior, when raised by both biological parents.

Another protection from risky sexual behavior is strict or close parental monitoring. Parental monitoring is usually defined as knowledge of the child's whereabouts, activities, and friends at any given time (Jacobson & Crockett, 2000). In contradiction to the premise that close parental monitoring reduces risky behavior, two of the five teen mothers perceived that they were raised with strict monitoring. Strict monitoring provides protection against behaviors far riskier than teen pregnancy. Loretta, a 24-year-old Latina, observes how she was impacted by strict monitoring:

> I hung out a lot. My boyfriend growing up was in a gang and the kids that I hung out with did drugs and they were dropouts. Some of them didn't have their parents or their parents were split up. Most of everybody was Hispanic/Mexican American. They just kind of partied all the time, which I couldn't because my mom was more strict on me. I kind of wanted to fit in with them and did dumb things just to hang out with them. I was influenced by them but I didn't get to the point where I was a druggie and such a bad person. I still had my morals. My mom still kept on me all the time, so, I was just a good girl trying to be bad.

Loretta describes what it was like trying to fit in with the gang of adolescents who were taking drugs and skipping school. She saw that her behavior was constrained by the strict monitoring of her mother. Although she had some involvement with the gang, she still viewed herself as a good girl just trying to fit in with those exhibiting bad behavior. Without her mother's watchful eye, she believed that she would have become one of the "druggies" or "a real bad" person.

The literature indicates that being raised by two biological parents is ideal, but single mothers raised 10 of the participants. American Indians experienced the highest incidence (4 of 6) of being raised by their mothers only. The next section reveals the importance of mothers in their daughter's development.

*Mothers*

The literature indicates that a strong mother-daughter relationship reduces risky sexual behavior across all cultural groups. When mothers openly communicate about intercourse, it is believed to promote sexual abstinence in the adolescent female and delay first intercourse, regardless of whether the messages are positive or negative (Resnick, et al., 1997; Sieving, et al., 2000). Similar to the messages in formal sex education classes, much of the communication between mothers and daughters focuses on negative aspects of sexual behavior, such as violence, loss of moral reputation, and male deceit to obtain sexual favors. The positive messages focus on instilling confidence and esteem-building in the adolescent female (Morrison-Beedy, et al., 2008). In this study, it is believed that a strong mother-daughter relationship would impact the communication about reproduction. Table 3 illustrates the strength of mother-daughter relationships in my participants.

Table 3.

*Close Relationship with a Mother*

| Race | Yes % | No% |
|---|---|---|
| Euro-American (n=10) | 4 | 6 |
| African-American (n=6) | 2 | 4 |
| Latina (n=6) | 1 | 5 |
| American Indian (n-6) | 2 | 2 |
| Totals (N=28) | 9 | 19 |

As shown in Table 3, 19 of the participants did not have a close relationship with their mothers, but 9 did. In my study, Euro-American females had the closest relationship with their mothers of the four racial groups. Next, African-American and American Indian females had slightly more distant relationships than Euro-Americans, but closer than Latinas. However, I did not find the strength of the relationship to be a good predictor of communication about reproduction. Of the nine participants who reported having a strong relationship with their mothers, only 4 learned about adolescent sexuality from them. This suggests that there is not a strong correlation between a close mother-daughter relationship and communication about issues of sexuality.

The communication varied from minimal to comprehensive within and across racial groups. I will analyze mother-daughter communication by the following criteria: 1) a strong mother-daughter relationship in which sex is discussed; 2) a strong mother-daughter relationship in which sex is not discussed; 3) a distant mother-daughter relationship in which sex is discussed, and 4) a distant mother-daughter relationship in which sex is not discussed. An example of each criterion is given below:

Camile, a 20-year-old Euro-American who describes her relationship as close and had the following discussion about reproduction with her mother:

> My mom would teach me while watching movies. She would say, "Do you know what they're doing?" and then she would explain. She was always just really open about it and answered questions. In elementary school people would talk about it [sex] on the playground. I'd go home and ask questions. I always felt like I could do that and I always felt like my mom would answer them truthfully and honestly.

Betty, a 23-year-old African-American, who defined her relationship with her mother as close describes the following discussion about sex with her mother and father:

> It was in sixth grade. My mom and dad sat me and my sister down and they said, "There are going to be people in middle school now that will tell you things to do. Don't do it. Don't pass notes. Don't do anything. Don't have sex." My sister and I say, "Oh", and my parents say, "Just don't do it." and that was the extent of it until I got to like biology. Yeah, we still don't talk about sex.

Karney, a 22-year-old Euro-American, who does not report a close relationship with her mother, has the following discussion about reproduction:

> My mom was a nurse and I remember her pulling me in and sitting me down before I even knew what was going on. And she read me "Where do I come from?" and we went through that book and kind of talked about … She was real open with [about], how babies are made, and what goes on, and special relationships between men and women. And before I'd hit puberty, she sat me down again and read me, same author, "What's happening to me" about going through puberty and different things that happen with that. And she was just very vocal and open about all those things, even about masturbation and stuff

> like that, before I even knew what she was talking about. She said, you know, if you touch yourself, you need to go wash your hands. And you need to go to the bathroom and all kinds of stuff. And I had no idea what she was talking about. But later on, it was like oh, okay, that's useful information now so…

Loretta, a 24-year-old Latina, who does not have a close relationship with her mother, describes how the issue of reproduction was addressed:

> My mom is very old-fashioned Hispanic. I never heard her even say the word sex. I knew that there was sex out there and you can get pregnant. I knew about period things but she did not mention it to me.

Camile and Betty both describe their relationships with their mothers as close. Camile receives age-appropriate comprehensive sex education from her mother while Betty does not. Camile's mother discusses sexual issues as they present in movies. She uses topics relevant to a child. There is an openness that allows and invites questions as they arise. In contrast, Betty is given the message, "Just say no." She understands that there will be no discussion.

Karney and Loretta both describe their relationship with their mother as distant. Karney's mother started teaching her about reproduction by reading books when she was very young. As she developed, the topics progressed from basic biology, to sexual activity including masturbation. Karney describes her mother as being very open about reproductive issues. Conversely, Loretta does not receive information about menstruation or any other reproductive issue.

Camile and Karney, although one describes her relationship with her mother as close and the other distant, were both taught comprehensive sex education from their mothers. Betty describes her relationship with her mother as close, while Loretta does not. Neither participant was taught about reproduction from their mothers. Further

exploration is needed to determine what factors influence discussion about reproduction between mothers and daughters.

There are potential factors regarding the mother that go beyond a close relationship that influences the discussion of reproduction. Some of the factors include: 1) her perception that discussion is appropriate, 2) her lack of skill to discuss reproduction, 3) her belief that discussion would encourage sexual activity, 4) her belief that she can prevent sexual behavior by monitoring, and 5) religious beliefs that silence the discussion. Effective communication would be stifled by any of these factors.

The majority of the participants did not learn about reproduction from their mothers. My research findings support the need for future research to explore the reason sex education does not occur between mothers and daughters. Additionally, the findings support the need for comprehensive sex education to adolescent females from a source outside the home.

*Aunts and Uncles*

After discussing the primary caregivers, the participants were asked to name other important adults with whom they had a close relationship. Aunts and uncles were frequently named as reported in Table 4.

Table 4.

*Important Relationships: Aunts and Uncles*

| Race | Not Important | Aunts only | Uncles only | Both |
|---|---|---|---|---|
| Euro-American (n=10) | 1 | 3 | 3 | 3 |
| African-American (n=6) | 1 | 3 | - | 2 |
| Latina (n=6) | 1 | 2 | 1 | 2 |
| American Indian (n=6) | 3 | 1 | - | 2 |
| Totals (N=28) | 6 | 9 | 4 | 9 |

As Table 4 indicates, 18 participants felt one or more aunts were important to them, and 12 felt one or more uncles were important to them. Some participants were close to both aunts and uncles. Uncles were most important to Euro-Americans and Latinas, but the descriptions and elaborations of the relationships were much briefer about uncles than about aunts. Uncles were described as substituting for a father or a brother. While all four racial groups valued aunts, they were most valued by African-Americans (5).

There was a wide range of roles assigned to aunts. Bee, a 25-year-old African-American, described her relationship with her aunt who provided emotional and financial support:

> My Aunt Darby, which is the youngest one, just like we would go on band trips and I didn't really have a lot of money. She would always borrow money and give me money. But she was always helpful, used to always do stuff with me or go places.

Brenda, a 28-year-old African-American, described her relationships with multiple aunts and the security she felt by knowing that they were available to her:

> At one point in our lives, and we don't see much of each other now, but because we saw much in the important years, through the nurturing years, the growing up years. We're still … I don't call and talk to them every day. But I know that if something happened to my parents, when I was growing up, I would have someone to take care of me. And I would have somewhere to go. I know that if I called now and said I'm coming to Arizona, I need to stay somewhere. I'm coming to this place. There's no problem, you know, because that's the kind of family that we have. And they would, you'd just fit right in.

Ally, a 21-year-old American Indian, described her relationship with her aunts and their children based on the inclusion she felt in visiting them and sitting at the dinner table:

> Another aunt, she lives in a small town in Oklahoma. I see her more often than just on holidays- just the distance thing. I'm a little bit closer with her than I am with the first aunt that I had talked about. Her daughters are like right around the same age as me. So me and those cousins in particular have been real close. We've spent a lot of time at each other's houses and things. And I have another aunt and her name was Rachelle. She lives here in the city and her and my mom are the closest in age and they have always been just right there with us. Her and mom were always close. Her daughter, which is my cousin, we were just a couple years apart actually, and we grew up really close. So I'm really close to my Aunt Rachelle. We were over there a lot and my fiancé and I, when we go over, she's like well, come over and have dinner with us. Just stuff like that. She's the closest aunt that I'm the closest with.

Chris, a 21-year-old Euro-American, described her relationship with her aunt as one that provided more than financial support, emotional security, or general inclusion:

> My aunt is just goofy as hell. She's a science teacher at a private school and she's kind of like the crazy wild card of the family who just says whatever she wants and doesn't care about anything, you know. Everyone loves her. She just gets along with everyone. She and I just have a connection because we, just bullshit back and forth and we'll just be goofy together. So that's how that functions. Yeah, I kind of consider her and I to be pretty similar personality-wise and she's

> very strong, very independent, and a very driven woman, which is what I aspire to be.

From this description, it is evident that Chris respects her aunt as a role model. She aspires to be strong and independent and sees herself as powerful. As discussed in the literature review, empowerment is an important factor in reducing risky sexual behavior (Toman, 2002).

The literature on adolescent sexuality is silent about the importance of aunts and/or uncles to adolescent's romantic relationships. However, this study showed them to be valuable players in promoting healthy decision-making. Additionally, aunts and uncles were described as significant family members to the adolescent females across all racial groups. Although only a few of the participants explicitly stated how the aunts guided them in romantic relationships with no one describing their experience with uncles, most viewed aunts and uncles as being collectively influential in development. Why couldn't aunts and uncles be important players in promoting healthy romantic behavior in adolescent females?

*Grandparents*

Grandparents were closely ranked behind aunts and uncles as important figures in the lives of female adolescents. Some of the participants viewed their grandparents collectively as being important while others specifically named either grandmother or grandfather. Table 5 reflects the emphasis participants placed on the role of their grandparents.

Table 5.

*Important Relationships: Grandparents*

| Race | Grandparents | Grandmother Only | Grandfather Only | Not Important |
|---|---|---|---|---|
| Euro-American (n=10) | 3 | 1 | - | 6 |
| African-American (n=6) | 2 | 2 | 1 | 1 |
| Latina (n=6) | 1 | - | 2 | 3 |
| American Indian (n=6) | 1 | 2 | - | 3 |
| Totals (N=28) | 7 | 5 | 3 | 11 |

Brenda, the 28-year-old African-American, who described a close relationship with her aunts in the previous section, also described her relationship with both of her grandmothers in the following way:

> Grandma, she's the community grandmother, so everyone in the community would know her. She does the big family dinners that are traditional in African-American families. She's the one that would host those. And so every time she comes to my house, her main concern if she walks in is, "Oh my gosh, I am so proud of you." It's just like I will keep my house just so neat and so clean. And then if my other grandmother would have came, she would have said "Oh, I see books about the Bible. I'm so glad that you're close to God and He's just there and you just make me so proud." So whenever they're around, it's just hilarious. But they complement, the two of them are complete opposites.

The description of the family and the two grandmothers were told with great pride. She told the story with humor to emphasize the differences in the grandmothers: one

grandmother likes physical cleanliness, and the other wants her to have a spiritual relationship with God. The real significance of the story reflects how important both grandmothers are to Brenda and her desire to make both of them proud of her.

Laura, a 29-year-old Latina, described her grandfather with great affection:

> He could do absolutely anything. He could fix anything. I mean, he was just phenomenal. I remember- and I tell everybody this- he fixed my plastic flip-flops when I was like five with a piece of chicken wire. Don't ask me how he did it, but it did not affect the little plastic between my toes. It had snapped and he fixed it, and I was just like, ohhh, because it was my favorite pair of flip-flops ever. But he could do anything. He could fix anything. And very, very loving, just all the time here.

Laura's description of her grandfather reflects a memory of him fixing something that was very important to her as a child. The importance of this memory is revealed by her summary, "He was always there and always loving." Her grandfather was a source of stability in her life.

Arlene, a 23-year-old American Indian, described her relationship with her grandparents in the following way:

> I'm really, really close with my mom's mom and dad. I talk to my grandma daily. I mean, go over there all the time. My grandpa, owns a large western store, so we do lunch once a week and stuff like that. He (grandpa) used to work a lot, but he was always there. I've been still closer to grandma just because she's grandma. I still, I'll tell her stuff before I'll tell my mom stuff. I don't know why but, just the relationship. She's very sensible and she'll let me know whether I'm the one that's being wrong, or someone else is. They're people that I'd like to be like some day.

Arlene's relationship with her grandparents indicates that they were a stabilizing force in her life. Her grandfather was always there. Her grandmother offered sage advice. Arlene sought advice from her grandmother more frequently than from her mother, indicating the value she placed on her grandmother's relationship. Her desire to model her life after her grandparents has implications for her decision-making.

Clearly, extended family members are important to female adolescent development as role models, advisors, and confidants. However, some participants (5) disclosed that they felt more comfortable discussing sex or reproduction with their extended rather than nuclear family. Emotional support is frequently needed by adolescent females with concerns about their romantic relationships. Sex educators and healthcare providers should utilize the extended family relationships when counseling with adolescent females.

## Performance in School and Extracurricular Activities

### *School Performance*

Higher levels of education are associated with greater economic outcomes, increased social and psychological resources, and fewer risky health behaviors. Education equips individuals with improved cognitive skills and more general knowledge to achieve better life outcomes (Saegert, et al., 2006). Each participant was asked to self-report her performance in high school on a scale of good, fair, or poor. Table 6 reflects high school performance.

Table 6.

*High School Performance*

| Race | Good | Fair | Poor |
|---|---|---|---|
| Euro-American* (n=9) | 7 | 2 | - |
| African-American (n=6) | 5 | - | 1 |
| Latina* (n=5) | 5 | - | - |
| American Indian (n=6) | 3 | 2 | 1 |
| Totals (N=26) | 20 | 4 | 2 |

* One Euro-America and one Latina did not provide information

As previously mentioned, my participants were classified in the range from upper-working class to middle class, in part based on their educational levels. In Table 6, participants report mostly good performance in high school. Table 7 reflects the cumulative educational attainment of my participants.

Table 7.

*Educational Attainment*

| Race | HS or GED Only | Some College | Completed Bachelor | Completed Master and > |
|---|---|---|---|---|
| Euro-American (n=10) | - | 7 | 1 | 2 |
| African-America (n=6) | - | 3 | 2 | 1 |
| Latina (n=6) | 3 | 3 | - | - |
| American Indian (n=6) | 2 | 4 | - | - |
| Totals (N=28) | 5 | 17 | 3 | 3 |

The overall educational performance of participants was very high. The school achievement and percentage that completed high school was above average compared to the national and state statistics. Oklahoma falls below the national average for educational attainment. National statistics for high school (HS) or equivalency is 87% compared to Oklahoma's 72%. My participants all had HS or equivalent completion. National statistics for attaining a bachelor degree is 29.6% compared to Oklahoma's 14.5%. The percentage of my participants obtaining a bachelor degree is 6 (21.4%) which is lower in my study than the national average but higher than Oklahoma averages. However, many of the participants were younger than 26 (the age of the participants in the national data) and were attending college at the time of the interview.

Not only was the performance and educational attainment high, those who were teen parents obtained more education than the national average. While it is estimated nationally that less than 40% of females who give birth at the age of 17 or younger do not finish high school (Hoffman, 2006), 1 of 5 the teen parents in my study did not complete high school which is lower than the national estimate. Furthermore, 4 of the 5 teen parents described their school performance as good despite their pregnancies. This deviation from national standards suggests that there were other contributing factors influencing school performance. One factor might be that my participants did not include adolescent females at the lowest socioeconomic level. Family, socio-economic status and culture are potential contributors that will be explored below.

Poor school performance can indicate difficulties in the home. Aryan, the 24-year-old American Indian woman, stated that her school performance was poor because she had family responsibilities. When asked if there was a time she did not have stress from her home life, she described the following:

> Hmm, I think my senior year, because when I lived at home with my mom. Well, there was only one year that I lived with her and she was doing well. I still had to help with the kids but my senior year, I moved out of my dad's and I didn't go back to my mom's. I went and moved in with my dad's brother and his wife. And I think it was the spring of my senior year, but I went to school. I didn't have to help take care of anything. I worked and just had to worry about me. But then I got pregnant. So, up until I started showing, I only had probably like four months, because then I moved in with my kids' dad so really probably just my senior year. That was probably the time that I didn't have to worry about anybody else or anything else besides just me.

Helping raise her brothers and sisters was very stressful for Aryan. The burden kept her from performing well in school. When she is going to school and working, without family responsibilities for her siblings, was a time she recalled as being relatively carefree.

Poor or declining school performance can be an indicator of family stress. Adolescents experiencing family stress may turn to peers to seek intimacy that is not available in their families. Adolescents, whose school performance declines, should be assessed for emotional and/or familial stress in an attempt to thwart risky behavior. Adult intervention during a time of family stress could guide adolescents to explore in healthy arenas and avoid risky sexual behavior that results in STDs or pregnancy.

*Extracurricular Activities*

To reinforce patterns of high educational achievement, all but one of my participants was involved in extracurricular activities. She liked to read, shop, and go to the movies with her friends. Her lack of extracurricular activity was not due to limited income. Extracurricular activities included sports, band, choir, and academic clubs. Some participants were involved in multiple activities simultaneously. There were no emerging trends or patterns within each racial group. The participation in extracurricular activities indicates that all participants had the financial and social support needed to participate. The examination of extracurricular activity did not provide insight into the behaviors of the participants.

## Family Income and Occupation

Family income and occupation can impact school performance and participation in extracurricular activities. There was no specific interview question regarding the level of family income or occupation of participants' parents, but none reported that their basic needs (food, clothing and shelter) were neglected due to poverty or parental job stress. Although a general assessment of participants' needs was made, the occupation of the caregiver's occupation was not addressed.

Three participants lived with extended family members due to financial and/or behavioral problems. However, participants' stories do not reflect a deprivation of basic needs within their families. Additionally, their high level of involvement in extra-curricular activities and good high school performance suggests adequate financial stability to support these activities. These findings reinforce my view that all participants appeared to be within upper-working to middle class range. Hence, no assessment about how the caregivers' occupation and overall family income impacted adolescent development could be made.

## Reproductive Education

The source of reproductive knowledge is of major interest to this research study. Comprehensive knowledge about reproduction and sexuality assists adolescent females to determine how they want to participate in and engage in decision-making about romantic relationships. The participants were asked where they learned about reproduction. They were not limited to one response. The majority of responses fell into the categories of mother, school, and peers. Other resources of reproductive information included books, aunts, clinic nurses, and dad, to name a few. Some participants received the information from a single source; others reported learning about reproduction from multiple sources. Table 8 reflects these findings.

Table 8.

*Learn About Reproduction*

| Race | M | S | P | M&S | M&P | M&S&P | P&S | O |
|---|---|---|---|---|---|---|---|---|
| Euro-Amer (n=10) | 3 | 2 | 1 | | 1 | 2 | 1 | |
| African-Amer (n=6) | 1 | 3 | 1 | | 1 | | | |
| Latina (n=6) | | 3 | 1 | 1 | | | 1 | |
| Amer Indian (n=6) | | 1 | | 1 | | | 1 | 3 |
| Totals (N=28) | 4 | 9 | 3 | 2 | 1 | 2 | 3 | 3 |

M=mother
S=schools
P=peers
O=other

Approximately a fourth of the participants reported learning about reproduction from multiple sources. Having more than one source did not seem to improve the comprehensiveness of the information. The source most frequently named was the school system for 16 of the participants, with little variability across cultures. School sex education programs were reported to have similar curricula that lacked comprehensiveness. There was more cultural variability for mothers and peers as discussed below.

Six Euro-Americans learned about reproduction from their mothers, compared to 2 African-Americans, 1 Latina, and 1American Indian. Five Euro-Americans learned about reproduction from their peers, compared to 2 African-Americans, 2 Latinas, and 1 American Indian. The findings indicate that culture influences how we learn about reproduction. Comprehensive sex education programs in the school could improve the amount of reproductive knowledge received by all cultural groups.

*Mothers*

Mothers were a source of reproductive information for nine of the participants. As discussed previously, a relationship was not found between the strength of mother-daughter relationships and whether the daughter learned about reproduction from her mother. In this section, the impact of the mother's positive or negative messages about reproduction and sexuality will be explored.

Karney, the 22-year-old Euro-American discussed earlier, suggested how her mother's guidance prepared her to avoid risky sexual behavior.

> I don't know. I am very glad that I had the opportunities that I had, especially with a mother who was very open to birth control and protection and not just the emotional and mental state of minds about being a woman. Also physical relationships with people. She prepared me very well. I think that I could have made some mistakes if I had not had access to birth control. And so I am glad that I had it and I'm glad that I have it. It's important to me that I finish school and that I get the things that I want to do done before I have children so that I can provide them with the same kind of information and optimism that I received, because I don't want to resent my kids, for keeping me from doing something that I wanted to do.

This comment suggests that the Karney recognizes that her mother provided guidance to protect her mentally and physically from the risk factors associated with sexual activity. This protection included access to birth control that protected her from teen pregnancy. Karney says that her mother empowered her to make choices in romantic relationships.

The value she placed on her mother's guidance was particularly evident when she stated she wanted to provide her own children with the same education her mother provided her.

A contrasting experience is described by Bernie, a 26-year-old African-American, discussed earlier, who thought that her mother did not trust her when she had her take birth control pills at the age of 12. Bernie had no interest in sexual activity at that age despite the fact her mother required her to take birth control. When Bernie did become interested in sexual exploration, she felt that the birth control pill encouraged sexual activity. She was given contraception protection before she needed it and when she initiated romantic relationships, there was no additional information concerning emotional involvement or protection against STDs.

Unlike the two previous stories, Kitty, a 20-year-old Euro-American, did not want to talk to her mother about romance and sexual activity. When asked with whom she could discuss sexual matters, she responded: "I think that my mom would have wanted me to talk to her about it, but I would never. That feels weird." Kitty's mother conveyed openness to discussion of sexual matters and talked to Kitty about reproduction. However, Kitty was uncomfortable talking to her mother and preferred to talk with her peers.

In these three cases, different perspectives about mother-daughter relationships and discussion about reproduction and sexual activity are presented, ranging from a total lack of communication to open discussion of sexual activity, with strategies to manage emotional and physical risks. Although the mother-daughter relationship is

important, mothers were not always the most frequent source of sex education. These findings support the need for comprehensive sex education in the school system.

*School Sex Education Programs*

Sex education in the school system has been a hot topic for many years. Although the literature suggests that most parents (80%) prefer a comprehensive sex education program for their children (Freking, 2008; Sexuality Information and Education Council of the United States, 2004), abstinence-only sex education was the dominant source of sex education for the participants in my research study. Most participants were very vague about what they learned in school about sex education. Many indicated that they learned about menstruation in elementary and junior high, while some received information about reproduction in high school.

Only one participant, Anna, a 24-year-old American Indian, described involvement in a fairly comprehensive sex education program.

> I remember it was the 5th grade, they told us someone would come to our class. They pulled the boys into a different room and they let us girls in one room. They told us about reproduction and getting the menstrual cycles and birth control and condoms and all that stuff. They gave us all these booklets. Well after that, the set of friends I had then, we were all laughing and joking around about it. And then we started talking about terms like masturbation and we would just laugh with each other about it.

Although Anna described a comprehensive sex education program, most participants indicated they learned about reproduction in school with no mention of birth control, condoms, or masturbation. No one reported learning about the emotional involvement related to romantic relationships in their school programs. This absence of information leads to uninformed decisions about romantic and sexual activities which can result in pregnancy, STDs, and other emotional consequences.

One of the latest news releases from the CDC reported that one in four adolescent females contracts an STD (Center for Disease Control and Prevention, 2008). Although STDs were not reported by any of my participants, the national statistics suggest that STDs are a big problem for adolescent females today. With such a high national average of STDs, it's critical to find a way to teach the risks of unprotected sexual activity in a meaningful way to our adolescents.

This study shows that schools are the primary source of reproductive information to adolescent females across cultural groups. Currently, comprehensive sex education is not part of most school curricula, and budget cuts are reducing many programs. I fear that comprehensive sex education will not receive the funding or attention that it needs. The school system is an ideal place to disseminate comprehensive sex education programs to all adolescents. While it is important to learn how adolescent females learned about the mechanics of reproduction, it is even more important to understand how they developed their own concept of the ideal romantic relationships. The following section considers this topic.

## Constructing Romantic Relationships

Physical changes occur rapidly in adolescent females that are triggered by hormones stimulating thoughts about romantic relationships. The process by which adolescent females develop an ideal type for romantic relationships could provide an understanding of how they make decisions in a romantic relationship.

### *Observing Others*

Many participants stated that they made decisions about their own relationships with boys based on observations of others. Twenty-five percent of the participants (four

Euro-Americans, two African-Americans, no Latinas, and one American Indian) said they wanted a relationship that resembled the relationship between their mother and father. Betty, a 23 -year-old African-American, described her parent's relationship as one of dedication and commitment through disagreements.

> My parents' relationship, they've been together forever, like 27-28 years or something. But I mean, they fight. They get into it. But at the end of the day, my parents are all they have. Like that's it for them. Even my dad has said that to my mom. He's like you're it for me, babe. I'm not going anywhere. They're cute. My dad reads a lot. So my mom will just sit there in the kitchen cooking and he'll read his book at the counter and … They're cute. I love them! They're great!

Connie, a 28-year-old Euro-American, described her parent's relationship as one that taught her the importance of respect and communication in a relationship.

> Probably a lot of it's based on my parents. Umm, even though, you know, I harass my mother about my father, they are very loving to each other and very respectful of each other and that was probably the two most important things. But it was definitely their relationship. I mean, they got mad at each other, but they always talked through it.

Anita, a 24-year-old American Indian, described her parents' relationship based on a romantic notion of love. She balances the dreamy statement about being soul mates with the realistic recognition of anger and fights.

> Yeah, my parents. I mean really they're each other's soul mate. They've been together for 35 years. They dated for five years and then they got married. So they still love each other. They still look at each other as if they were 18. They moved and they were stressed out all the time, angry all the time, but through all that, they still love each other, care about each other, and it didn't affect their relationship.

Each of the examples has a romantic quality, but also has a conflict negotiation component. The qualities identified are dedication, commitment, respect, and love.

Some relationships violated participants' image of an ideal romantic relationship. Fifteen participants said that they learned what they did not want in a

relationship based on watching others, such as parents, grandparents, peers, or siblings. The characteristics of the relationships that they did not like included verbal and physical abuse, jealousy, and lack of respect. A study by Martyn and Hutchenson (2001) described how African-American adolescents overcame potential risky behaviors based on rewriting negative life scripts. Several of the participants in my study constructed their ideal relationship by metaphorically rewriting their negative psycho-social life scripts.

Cassie, a 19-year-old Euro-American, described what she would like in a relationship, partially based on this theory. In her story, she expressed some embarrassment about her family. Her mother was married four times and both of her grandmothers were married six times. Cassie had a lot of boyfriends when she was in junior high and high school. She disliked the emotional pain attached to breaking up with a boyfriend. She was looking for some stability in her life and found that stability in a local church where she embraced its teachings. Cassie credited her affiliation with the church for her desire to develop a relationship with a man before becoming sexually active again, in hopes of forming a more stable relationship than those formed by her mother and grandmothers. Her statement about not wanting to repeat the pain of a break up not only reflected her own personal pain experienced in her romantic relationships, but her family problems. Cassie stated that she wanted to avoid pain entailed with poor decisions about romantic relationships.

> It's chastity and marriage and life is really important. And that's kind of where I've gotten my ideas [her church] plus looking at my family tree. My family is not like together at all. They're just very spread out, very kind of I guess dysfunctional and I don't want to be any... I don't want to have any part of that. I don't want the pain of that kind of thing in my life or in the life of any kids that

> I'm going to have. So just for my own personal self I believe that I'm going to wait until I get married to be with somebody again, I guess.

Similar to Cassie's story, Belinda, a 22-year-old African-American, stated her expectations of romantic relationships by re-scripting her mother's relationships in order to determine what she did and did not want in a relationship:

> Well, from looking at my mother's relationships and I learned then what I didn't want. I don't want somebody that is going to take away from me and my character. I understand compromise but not to the point where I lose myself. I don't want somebody that's abusive, that's constantly being negative. I'm an optimistic person. I want somebody that can take care of me, not necessarily I need them to take care of me, but that they can take care of me and is willing to. Somebody that's strong-minded but not over-communicative. Somebody that is always 50-50.

Brenda, a 27-year-old African-American, described her parents' relationship in its positive and negative characteristics and how it shaped her own relationship by close observation:

> I mean because it is based on, looking at the fact that, even something in my parents' relationship I'm not going to deal with. Like my dad is jealous and I'm not going to deal with that. I don't want to be with somebody that's jealous, you know. That's good for you guys, but it's not good for me and so I can shape the things that I really like. I really like the way that my dad holds my mom. I really like the fact that he will give everything to make her happy. I really like the fact that he will just break his back to provide. He's like the type of father that I want my husband to be, the type of provider, and the way I want him to treat me. My dad always makes this joke. He's like all you need is the keep of a woman. And I got mine and a cup of Koolaid, and that's what he would always tell my aunt's boyfriend.

Other references to good and bad relationships included peers, siblings, aunts, uncles, and grandparents. Participants described behaviors that they found appealing and unappealing. The negative behaviors were examples they planned to avoid in their own romantic relationships and the positive ones they admired and wanted to emulate. The

scenarios described the importance of family relationships in the construction of adolescent females' romantic relationships.

*Independent Role Identity*

One's gender role identity plays a significant part in constructing an ideal romantic relationship. An independent identity, one that supports equality and a sense of entitlement to that equality, helps define one's role in romantic relationships. As previously discussed in the literature review, an independent nature is assigned to male-gendered characteristics and is related to power in relationships (Abrams, 2003). Thus, an independent nature in adolescent females counters the gendered disparity of power in romantic relationships by displacing submissive or passive behavior (Taylor, et al., 1995).

Participants' self-perceived power and independence were explored to examine whether healthier romantic choices were made if adolescent females had a sense of independence and power. Determining how an adolescent female comes to know herself as being independent and strong was explored in the interviews. Seven participants told stories in which they identified themselves as having an independent nature: 3 Euro-Americans, 2 African-Americans, 1 Latinas, and 1 American Indians. The findings represent all cultural groups, but Euro-Americans and African-Americans were more likely to possess this characteristic.

Euro-Americans indicated that their sense of power and independence were derived from several different sources. Connie, a 28-year-old Euro-American, described how her parents expected her to develop independent behavior by obtaining an education.

> My goal was to know I could be independent and self-sufficient and not need anybody else. I could make a life for myself if I needed to. But if I found somebody that could make me happy and we could do it together, then that would be bonus. So, and that's what my mom and dad exhibited. It was always important to keep the skills up, the intelligence up, so you could always do that. And the way to accomplish that was education and I had to do my job. And it was my job, umm, in high school and college to get my education and that was my only objective. So when I wanted to go and get a job, I had to convince my parents that I could go and get a job because my job was my education. So I got a free ride through everything because that was my goal.

This description of independence represented her goal-oriented plan. She saw her parents demonstrate a lifestyle that she wanted to emulate, and they defined the path to her independence. Her sense of confidence and power came through in her assertion that she could accomplish her goals. Connie's desire to be independent aligns with male gender characteristics.

Chris, a 21-year-old Euro-American, derived her independence from her high school experiences. Her school empowered her and her peers to be independent. Chris also exhibited romantic behavior that was developmentally appropriate and not considered high risk:

> Our high school was really special. It really promoted independence and being a strong woman and all that kind of stuff. So there was never any pressure. There was never any boys at school. So we never felt pressure to put out. And empowerment of yourself and things is what we were taught. So I never felt pressured. We never felt like we were lacking because we weren't having sex with our boyfriends and our boyfriends never pressured us, too. They were very upstanding men, you know, very good to us, with all of them. I mean we all were getting close to … we were all very physical with our boyfriends but like none of us were sexually active. But we were kissing and touching, stuff like that.

While discussing how her school promoted independence, Chris provided an interesting perception of sexual activity. She stated that the boys never pressured the girls to have sex, and the girls did not feel a social need to be sexually active. The statement referring

to the boys as upstanding indicates a moral judgment that if the boys had pressured the girls to have sex, it would have been behavior without honor. She continued with the thought that none of her friends were sexually active, although they were enjoying the kissing and intimate touching with their boyfriends. This behavior is safe and developmentally appropriate for high school students. The language she used in telling her story indicated a sense of pride in how her school contributed to her adolescent development and her strong sense of self and others.

Briana, a 21-year-old African-American, described her relationship with her aunts as creating a strong sense of self and power.

> They always told me that I could do whatever I wanted to. And like you start believing when you hear it every day. And so I was just like well, if I want to go to the moon, I can go to the moon. So whenever I put my mind to something, I do it because they always told me that I, like for them, I could stay on top of the world. Like that's just how they always put me so yeah.

This strong sense of self was not something that Briana was taught overnight but over years of interactions with her aunts. They established a strong foundation in which Briana was encouraged to be her own women before becoming involved in romantic relationships. There is an underlying gendered message of independence and confidence that hints of male gender identity.

Loretta, a 24-year-old Latina, told her story of independence as she combined the perspectives of her mother and father. For her, the messages of independence centered the responsibilities she was to assume as an adult:

> My mom did tell us, "You can do anything you want to do as long as you put your heart into it and you can be anything you want." My father as well, but my dad was more like, "You're a woman, you're going to look for stability." So I looked up to my father, a free man, an alcohol-free man. And I wanted somebody, and it's kind of weird because now I figure out that you are prone to look for men that are like your dad, the characteristics of a guy. And he was,

> well, you're a woman, you're going to find a man that's going to take care of you. And, once you're taken care of, if you want to do better. Then that's great but you're the heart of the home. So, for him, it would have been great if I could be at home with my kids. And my mom's more of a no, if you want to work, if you want to make more money, you go and do it. So those were the little things that they were different.

One message encouraged Loretta to pursue a primarily domestic role while the other suggested that she could have a professional career if she wanted more out of life. Loretta is currently trying to combine both roles in her life: raising her children with their father and attempting to complete her college degree.

American Indian females' construction of power is very subtle. By reading between the lines and hearing how indirectly and subtly the grandmother was a source of strength, Ally, a 21-year-old American Indian, spoke of her grandmother's influence on her:

> My family has never really been real emotional toward each other. We don't hug a lot and stuff like that and, cry and hold each other. We don't do that. And, so although I loved my grandma to pieces, I was crazy about her, and I know she loved me, too … I mean, she did hug and she was, you know, grandma. It was never really those kind of sit down and talk, let me be emotional with you. And let me talk to you and tell you, my feelings, how I feel, and how I want you to feel. I never had any of those. I think just the way she presented herself and the way that she conducted herself. I just think that's where I got it from. I always like to say I'm strong by nature maybe.

Unlike the African-American story of empowerment, the American Indian story was modeled by a grandmother who taught by example how one creates a powerful persona. Although Ally does not use descriptive terms to illustrate her grandmother's behavior, she tells us that there was a communication between them that was as effective as, or more so, than words or physical affection. Ally's statement that she is "strong by nature" implies that she has internalized all of the characteristics of her grandmother,

which would not be categorized as expressive, nurturing, and relationship-oriented. Hence, through her story, it is suggested that she has male gendered traits.

The participants described a variety of situations that they identified as empowering and instilling a sense of independence in their adolescent development. The sources included aunts, grandmothers, parents, and schools. Peers were not mentioned as a source for encouraging personal independence. The seven participants, who reported that they were encouraged to develop an independent identity, reflect the literature, indicating that a sense of empowerment is beneficial to negotiating a romantic relationship.

Additionally, among the participants who perceived themselves as powerful or independent, there were no teen pregnancies, and six out of seven did not become sexually active until they were 19 years of age or older. All of these participants rated their school performance as good. This strongly supports the view that the empowerment of adolescent females, be it from family members or schools, can protect them from risky sexual behavior despite other societal pressures.

*Sexual Desire*

Adolescent females are not encouraged to recognize their own sexual desire and may be encouraged to deny that they have sexual feelings. When sexual desire is denied, sexual experience may occur for reasons that are not in one's best interest (Tolman, 1991, 2002). A limitation to this study was that no questions directly asked about sexual desire. However, when I reviewed the transcripts for data on expressed sexual desire from the participants, I found that no participant referred to sexual desire

in the context of romantic relationships. However, some participants alluded to sexual desire when giving advice to their younger sisters which will be considered later.

## Relationships

### *Romantic Relationships*

Participants were asked at what age they started thinking about boys as more than playmates. This question effectively began the conversation about opposite-sex relationships. Some participants reflected all the way back to kindergarten and play with little boys, instead of romantic relationships. Hence, this question did not serve as a data gatherer, but it was a comfortable question that supported reflections about opposite-sex relationships.

The next question, "How old were you when you had your first serious boyfriend?" provided important data. The exact interpretation of the question was left up to the participants, which provided a variety of definitions of "serious." To some participants, their first serious relationship was the one in which they initiated first intercourse, while other participants thought of a serious relationships as being long-term. Race did appear to be a significant factor with regard to the age at which a participant had her first serious boyfriend.

Table 9.

*Age of First Serious Relationship*

| Race | 12 to 14 | 15 to 16 | 17 to 19 | Missing data |
|---|---|---|---|---|
| Euro-American (n=10) | 3 | 5 | 1 | 1 |
| African-American (n=6) | 1 | 3 | 1 | 1 |
| Latina (n=6) | 3 | 1 | 2 | - |
| American Indian (n=6) | - | 2 | 4 | - |
| Totals (N=28) | 7 | 11 | 8 | 2 |

As Table 9 illustrates, 3 of the Latina participants reported serious relationships between the ages of 12 and 14 while 4 of American Indians were not in a serious relationship until the age span of 17 to 19. Eleven of participants were involved in their first serious relationship at 15 or 16. It appears that culture influenced the age of romantic involvement. The role of culture in age of virginity loss was less noticeable.

Table 10.

*Age of Initiation of First Intercourse*

| Race | 12 to 14 | 15 to 16 | 17 to 19 | 20 to 21 | missing data |
|---|---|---|---|---|---|
| Euro-American (n=10) | - | 2 | 4 | 1 | 3 |
| African-American (n=6) | - | - | 2 | 2 | 2 |
| Latina* (n=6) | 1 | 3 | 1 | - | 1 |
| American Indian (n=6) | - | - | 3 | - | 3 |
| Totals (N=28) | 1 | 5 | 10 | 3 | 9 |

There was more missing data for the age of initiation of first intercourse than for the age of first serious boyfriend. There was no direct question for initiation of first intercourse. Twenty-six participants provided data about the age at which they had their first boyfriend, whereas only 19 participants volunteered information about their initiation of first intercourse. One participant had not been in a serious relationship or lost her virginity at the time of the interview. Another participant experienced sexual abuse at a young age which confounds the concept of virginity loss. Of the remaining 17 participants who reported age of first serious boyfriend and age of lost virginity, there appears to be a positive relationship between early age of first serious boyfriend and

early age of virginity loss. Other studies have concluded that initiation into romantic relationships at an early age is correlated with risky behaviors.

Teen pregnancy is one of the results of risky sexual behavior that is explored in the data. There were five teen pregnancies in this group, and three of the five teen pregnancies occurred to participants who initiated intercourse between 14 and 15 years of age. Of these three participants, the ages of first serious relationship ranged from 12-15 years of age.

Early adolescence is a time when abstract thinking is beginning to develop, but the ability to consider long-term consequences of decision-making is absent (Fonseca & Greydanus, 2007). The lack of ability to consider consequences of one's behavior was expressed by Loretta, a 24-year-old Latina, who became pregnant at 16. The message to her little sister directed her to avoid teen pregnancy. She states that being a teen mom has placed many constraints on her life. Her advice follows:

> If you're going to be doing something [indicating sexual activity], I can sit here and say, "You know, I don't want you to do it. I don't want you to go out with this guy thinking that you're going to be Romeo and Juliet with for the rest of your life, but you're not going to do it. You're going to do what you want to do. So if you're going to be stupid and do bad things, just remember that later your mom is not going to be there. Your dad is not going to be there. You're the one that's going to be living the consequences. So I said, "Look at me. I can't go out to the parties with my friends. I can't go to college and live in the dorm like I would like to do. Those are the fun times. Just think about all that." I just put it out to her straight, if you're going to be having sex, then you better use protection.

The quote reflects Loretta understands that an adolescent does not consider long-term consequences when she states, "You are going to do what you want to, but you will suffer the consequences of your act." In another quote, she said, "You think you are going to be Romeo and Juliet," here she refers to a romantic notion that motivates

young females to become romantically involved. Loretta also characterizes the act of having sex as stupid and bad, reflecting a moral judgment on her past behavior and giving a negative message to her audience. She tells us that she has missed the carefree life of being in college and living in the dorm.

Early adolescence is a time to discover individual differences between self and others (Fonseca & Greydanus, 2007). Many of the participants made recommendations to their little sister that they should get to know themselves before getting romantically involved and to avoid responding to peer pressure in romantic relationships. The following advice from Catrina, a 22-year-old Euro-American, explicitly described the developmental differences in her behavior before and after the age of 16:

> If you don't feel comfortable, just stop. That's all there is to it. And granted that's not as easy when you're in the situation, but that's the thing I didn't understand. I never understood that I could just stop it. I mean later on when I was 16 or 17, I did but when I was young, I felt out of control and I felt like it was something that I was supposed to be doing and I couldn't stop it if I wanted to. And so I guess that's it.

Catrina expressed the view that she made better decisions after she was 16 years old. This supports adolescent development theory about cognitive development in middle adolescence (ages 15-17), where abstract thinking and the ability to consider consequences of behavior is better than early adolescence (ages 11-14) (Fonseca, 2007). This is important in identifying multiple variables that impact behavior in romantic relationships. For example, despite education on women's health issues, self-empowerment, and positive modeling, a young adolescent may be limited in understanding the consequences of her actions due to her cognitive development.

Loretta's advice about the initiation of first intercourse in the above scenario differs from the descriptions of first intercourse that she and other participants reported

about their personal sexual debut. The advice has a negative connotation similar to the literature review that refers to first intercourse or sexual debut as virginity loss which is a negative term (Carpenter, 2005). My study had no specific question for participants about their first intercourse or sexual debut, but they were asked how their romantic relationships evolved. The language selected to describe their personal experience illustrated their perception of the event. The following descriptions were reported. Letty, a 29-year-old Latina, refers to first intercourse as "sexual activity." Karney, a 22-year-old Euro-American, Loretta, a 24-year-old Latina, and Laura, a 29-year-old Latina, describe their events as, "I lost my virginity". Bee, a 25-year-old African-American states, "We were dating for over a year before we actually engaged in having sex." Aryan, a 24-year-old American Indian, refers to her sexual debut in the following way, "He was my first boyfriend and the first one that I'd ever been with or, actually got to have anything with. So that was probably the first time." The language and tone used to describe their personal sexual debut is neutral, unlike the advice given to a little sister by Loretta with negative connotations. This is similar to many sexual references to first intercourse in the literature review.

*Peer Group Relationships*

In this study, I am interested in both the relationship between the participant and her romantic partner and the relationships between the participant and her peers. As discussed in the literature review, peer groups provide the social context for romantic relationships and influence the initiation of romantic development. Specifically, peers help to define appropriate romantic feelings, behaviors, and criteria for selecting romantic partners. Eventually, these romantic feelings and behaviors become

internalized as adolescents are socialized into romantic roles as defined by their peers (Cavanagh, et al., 2007). To explore the role of peers, participants were asked whether they had a peer group and if their peer group was same-sex or mixed-sex.

Table 11.

*Involved with a Peer Group*

| Race | None | Same-Sex Only | Mixed-Sex Only | Both |
|---|---|---|---|---|
| Euro-American (n=10) | - | 4 | - | 6 |
| African-American (n=6) | 2 | 2 | 1 | 1 |
| Latina (n=6) | - | 3 | 1 | 2 |
| American Indian (n=6) | 1 | 1 | 2 | 2 |
| Totals (N=28) | 3 | 10 | 4 | 11 |

As Table 11 shows, a majority of participants were involved with peer groups: 75% in same-sex groups and 53% in mixed-sex groups. Some participants in the mixed-sex group also stated that they also had same-sex group participation. Euro-Americans were most inclined to be part of a same-sex peer group. This finding aligns with the literature review. American Indians were the only group that favored mixed-sex peer groups (4) over same-sex peer groups (3). The literature states that members of mixed-sex groups learn social skills that are conducive to developing better romantic relationships than

those who only participate in same-sex groups (Cavanagh, 2007). Four American Indians also delayed first intercourse between the ages of 17-19.

Three participants (two African-American and one American Indian) were not part of a peer group and stated that they had little social contact with peers. Two out of three experienced teen pregnancy. In addition, one of the three was sexually abused as a child. My findings indicate that lack of peer involvement should be assessed for potential problems related to the lack of sociability.

Involvement in a peer group was further explored in the section, "Discussion of Romantic Relationships," in Chapter V. My study was interested in whether peers discussed romantic relationships and if the sexual activity of peers influenced their behavior. Hence, the participants were asked if they thought their peers were sexually active.

Table 12.

*Perception of Sexual Activity of Peers*

| Race | Yes | No | No Data |
|---|---|---|---|
| Euro-American (n=10) | 5 | 1 | 4 |
| African-American (n=6) | 5 | - | 1 |
| Latinas (n=6) | 4 | - | 2 |
| American Indians (n=6) | 2 | - | 4 |
| Totals (N=28) | 16 | 1 | 11 |

While there was some missing data (11) for this question, every participant except one believed that their peers were having sex. Additionally, only one participant out of the 16 stated that she perceived her peers were sexually active while she was not. This data suggests that the actions of peers are predictive of the actions of individual members of the peer group.

To determine if and how peers or other people influenced the participants' romantic relationships, the question "With whom did you discuss romantic relationships?" was asked. As Table 13 illustrates, 22 participants communicated about romantic relationships with their peers.

Table 13.

*Talked with Peers about Romantic Relationships*

| Race | Yes | No |
|---|---|---|
| Euro-American (n=10) | 9 | 1 |
| African-American (n=6) | 5 | 1 |
| Latina (n=6) | 4 | 2 |
| American Indian (n=6) | 4 | 2 |
| Totals (N=28) | 22 | 6 |

There were some differences between racial groups in these responses. Latinas and American Indians were more private than other groups about discussing their romantic relationships. However, they were the only two racial groups to share romantic relationship information with their sisters. Of the two participants that did share romantic relationship information with their sisters, one African-American and the other was Latina.

*Discussing Romantic Relationships with Family Member and/or Adults Nonrelatives*

Many participants used their peers as sounding boards about their romantic relationships, but not as many felt that they had any family member or adult non-family member with whom to discuss romantic relationships. Discussions with sisters are

discussed above. No one discussed their romantic relationships with their brothers. Three participants (one Euro-American, one African-American, and one Latina) discussed their relationships with their fathers and none experienced teen pregnancy. Three participants (one African-American and two Latinas) said that their mothers were available to discuss romantic relationships. Of these, there was one teen pregnancy where discussion of sexual activity occurred after sexual debut. One Latina participant revealed that she talked to a teacher about her relationships.

These numbers indicate that discussion of romantic relationships took place with peers more frequently than with adults. As shown in Table 14, 11 participants did not think that they could talk to adult about their romantic relationship. Unfortunately, after comparing discussion with peers and adults, 4 said they had no one (adults or peers) with whom they could discuss their romantic relationships. There was one participant from each cultural group in this category.

Table 14.

*Talked to an Adult about Romantic Relationships*

| Race | Yes | No |
|---|---|---|
| Euro-American (n=10) | 8 | 2 |
| African-American (n=6) | 4 | 2 |
| Latinas (n=6) | 4 | 2 |
| American Indians (n=6) | 1 | 5 |
| Totals (N=28) | 17 | 11 |

The participants' ability to talk to an adult about romantic relationships differed across cultures. Specifically, American Indian females were much less likely to discuss romantic relationships with adults. The following stories represent having no one or having no adult to discuss romantic relationships.

Brenda, a 28-year-old African-American, described her feelings about discussing romantic relationships with adults:

> No, never. Oh my God … no, never, no. Not to this day. No, never, never, never. I still don't think, no … I talked to my best friend and after that (lost virginity through date rape). I never spoke of it again ever until I wrote that paper. And I didn't realize how much it bothered me until I wrote that paper.

Lavone, a 22-year-old Latina, had similar feelings to Brenda's.

> It was a private matter just because I was always brought up to not having sex until after you get married. That was the only reason. And, no, I didn't even tell my sister or anybody. Until now, I'm not open about that stuff just with anybody at all, other than my boyfriend. And then that's, I mean … of course, we've been together almost five years. So I'm sure, they have an idea, but I'm never open about that stuff at all.

An American Indian and a Euro-American participant simply responded "no" that they never talked to anyone about a romantic relationship. Aryan, a 24-year-old American Indian, described her inability to discuss romance with adults as follows:

> The only ones that I ever really had to talk to was my friends. And they were the same age as me and had kind of gone through the same thing. I didn't have anybody to talk to until after I had already gotten pregnant and everybody knew that, figured I guess I was grown or something. Then that's when everybody started, talking to me. But otherwise as far as to try to talk to my mom, or having someone to talk to, I didn't really have anybody there because I was scared to because everybody had, pushed the fact that, don't get pregnant and especially my mom. I mean it wasn't just, I knew there's stuff, a lot of other kids don't tell their parents. But when you do need to tell them something or talk to them about something, I just figured I couldn't talk to her about anything. So I didn't really have anybody until after it was already done.

Aryan described her friends as being the same age and in the same situation, but she did not view them as a source of guidance. She was afraid to talk to anyone about her sexual activity because she had been warned not to get pregnant. Aryan also observed that there was a time she wanted to talk to her mother, who was unavailable until after she was pregnant.

Sexual identity and romantic relationships develop during adolescence. Adolescent discussion about romantic activity helps them define feelings, behavior, and criteria for selecting romantic partners (Cavanagh, et al., 2007). Although most of the participants were involved in a peer group and discussed romantic behavior in the peer

group, 11 did not have a trusted adult with whom to discuss or look to for guidance about romantic development.

The following example of a discussion about romantic behavior with an adult contrasts with the above cases where no adult was available for discussion. Bee, a 25-year-old African-American describes her conversations with her aunts:

> I talked to my aunts about it. They'd just ask, "Are you still a virgin?" I said, "No", and they said, "Well, when did this happen?" And I said, "Oh you know, about a year ago." And they were like, "Oh, okay. Well, you make sure you be careful, and let me know if you need anything". You know, just stuff like that.

Lena, a 24-year-old Latina also reported that her aunts were available to discuss romance.

Culture seemed to influence discussion about romantic relationships with peers and adults. Euro-Americans reported a higher incidence of discussion with peers and adults. American Indians had the least discussion.

Inquiry into participant discussion of romantic behavior uncovered two important messages. First, regardless of culture, 11 of participants did not talk to adults about their romantic relationships. There are a high percentage of adolescent females navigating through the development of sexual identity and romantic relationships without adult guidance, placing them at higher risk for unwanted outcomes of sexual behavior. Second, American Indians reported fewer discussions about romance and reproduction from family, peers, and other adults than other racial groups. This suggests that health providers and comprehensive sex education in schools could be powerful educational sources for all adolescent females based on the findings that some groups have fewer opportunities for discussion of romantic relationships. In addition, comprehensive sex

education programs could be used in after-school, peer group activities, community youth programs, and church youth groups.

## What Advice Would You Give to Your Sister?

One of the most important aspects of my research was to learn from the participants how to improve the adolescent developmental journey for younger adolescent females. Participants were asked what advice they would give to a younger sister about exploring romantic relationships. It aimed to elicit their insights about what was missing from their own adolescent sexual development. All participants had suggestions to improve the adolescent journey. After analyzing the responses, four common themes emerged: first, to develop one's own maturity before getting sexually involved; second, to identify experiences to explore and avoid; third, to make good relationship choices; and fourth, to take responsibility for the consequences of one's actions. Many participants gave advice that included more than one theme. All four themes encourage the adolescent female to take an active role in decision-making in romantic relationships. The themes will be discussed below.

### *Develop One's Own Maturity Before Getting Romantically Involved*

Exactly half of the participants made recommendations to their younger sister that she should develop her own maturity before becoming romantically involved. All African-Americans gave this advice. Euro-Americans discussed this theme more than Latinas and American Indians, which might have cultural underpinnings.

The messages had a variety of intentions. Some suggested that younger sisters should understand themselves before getting romantically involved. Others suggested avoiding peer pressure in the context of romantic relationships. This advice to develop

one's own maturity aligns with the literature that describes early adolescence as a time to discover individual differences between self and others (Fonseca & Greydanus, 2007). Additionally, it supports the literature that adolescents' cognitive development impacts their behavior in romantic relationships. More specifically, a high level of maturity is desirable before romantic involvement begins.

Catrina, a 21-year-old Euro-American, describes a lower level maturity before the age of 16:

> If you don't feel comfortable, just stop. That's all there is to it. And granted that's not as easy when you're in the situation. But that's the thing I didn't understand. I never understood that I could just stop it. I mean later on when I was 16 or 17, I did. But when I was young, I felt out of control and I felt like it was something that I was supposed to be doing and I couldn't stop it if I wanted to. And so I guess that's it.

Catrina's statement described a cognitive progression between her early adolescence and middle adolescence by stating that she did not understand that she could say no to sexual relations. This indicates that she was unable to differentiate her needs from those of others due to an immaturity.

Two other participants, Lavone and Arlene, reiterate the importance of understanding oneself and one's life before becoming romantically involved. Lavone, a 22-year-old Latina, offered this advice to her younger sister:

> The message I would want to give her would be wait until she is old enough to know how to handle everything herself instead of having someone else taking care of her. Of course, I would tell her to wait until she gets married, although I didn't follow that. But I would tell her that.

Arlene, a 23-year-old American Indian, suggests to her younger sister:

> My whole thing to her, [is] you have to have your own identity. If you don't go through life and make your own choices, what are you going to do when you don't have that person anymore? If you're not going to live your own life, then you're living for the wrong reasons.

A truly thought-provoking message was provided by Betty, a 23-year-old African-American, in which she encourages her sister to wait.

> That's so hard because I can give advice. But it almost doesn't reflect my life because I want to say wait, you have time, do your education. But in that same breath, I'm thinking I want to be married. I want to have a house, you know, in a couple years. I want kids, so I have that like internal conflict all the time because everyone tells me, "Oh, you're doing so good!" Just wait, you don't want to get married and get bogged down. But in my head, I do want to get married. I want that. I want to have a house. I want to have someone to come home to. I want to cook for someone. I want to do all that stuff. But if I had a younger sister, I would also tell her, "You need to wait. You have your life to do that." So it's kind of like I don't know if I'm in the place to give advice, you know. I don't know.

Betty understands the need to mature, but she also feels the desire to partake in romantic relationships to obtain her picturesque view of life: a house, a companion, and someone for whom to cook. This narrative describes the internal conflict involved in making mature choices while struggling with the concept of marital bliss and domestic roles.

*Identify Experiences to Explore and Avoid*

The second theme encouraged younger sisters to recognize experiences to enjoy or avoid. Euro-Americans contributed to this theme more frequently than the other racial groups. In the discussions, most of the participants emphasized painful situations to avoid. Colleen, a 26-year-old Euro-American participant, gave the following advice:

> Wait until you're married because you're having sex with these different people and you're having these emotional connections and sometimes they truly don't care about you. They just want what they want and then you feel like what happened, you know… you feel crushed. You feel like the world's ending, and you don't need to know that when you're having sex in high school and you feel like you're crushed, it's just scary because kids are killing themselves now over boyfriends and girlfriends and just wait … and wait to have kids.

Colleen's advice focused on two different experiences to avoid. The first was to avoid the mental and emotional pain resulting from sex in high school. The second, more straightforward advice was to delay pregnancy.

In a very similar fashion Cassie, a 19-year-old Euro-American, described the potential emotional pain associated with early sexual involvement:

> You can get yourself into a lot of trouble. So I would just tell them to wait until they're older before they even . . . And plus, it's like so painful, like you see these like middle school girls, like I was one of them, and they had these boyfriends that they just build their world around. And then you know, they're like 13-year-old boys so. They, in a couple of months, they're not wanting to be like going with them. It just crushes them. I don't know it's kind of a … It's just kind of a lot of effort for something that's just going to just hurt you anyway, I think.

Unlike Colleen's advice about avoiding sexual activity, Cassie warns that romantic involvement causes emotional pain when initiated in middle school or younger. Her direction is more inclusive than just sexual activity.

Belinda, a 22-year-old African-American, offered this advice about protecting oneself from boys that are deceitful:

> I try to explain to her that boys are not necessarily men. But boys aren't interested in you per se, boys will lie. Boys will do anything they can to get a piece of you and once you let them have a piece of you, there's no turning back. And every person, every partner that you're with, you give a piece of yourself to. And I always try to show her, just through my life, the things I went through, this person dragging me through everything, for what? And it wasn't true love. It wasn't true happiness. You might make a mistake on a relationship. That doesn't mean give up. But just know that you need to shield yourself more. Don't give a person all you have unless you know that that person is serious about you.

Belinda provides a different perspective on what an adolescent female should avoid in a romantic relationship. She describes relationships that ended, as taking parts of the adolescent that are not retrievable. She goes on to say that one should continue to get

involved, but to protect oneself from deceitful boys. It is advice that aligns with the historical messages that females are the gatekeepers of sexual activity and they must protect themselves from deceit.

Kitty, a 20-year-old Euro-American, gives positive advice, focusing on exploration in a romantic relationship.

> I think, I mean I'd probably say something about my experiences. But I think I would tell them, I don't think it's such a big deal. I think you should be open to experience. I think, "Enjoy it while you can." There's a lot to learn from it, about yourself and about going to school. I can probably say, I mean some of the things that my mom said to me about, being safe. But, I mean don't be afraid to be open about it I guess. The older I get and the more I learn about that, the more I feel validated in that opinion because I feel like a lot of girls, and that's the reason why people won't talk about it as much. I feel like, in this situation with my parents and my grandparents and all that and, they hand you the books or whatever and that's it. And I think that's just ridiculous. I think it's a better experience. I'm not saying you should go out and sleep with a bunch of people or anything like that. But I think if you wanted to, if you felt comfortable doing that, go ahead. And I think also … I think the whole … I know right now the abstinence is in the education. I don't think that's very good at all. It's horrible!

Catrina, a 21-year-old Euro-American, who commented earlier about maturity and its impact on decision-making, offered this advice about experiences to explore:

> I wouldn't say to not experience anything. I would encourage - I still would encourage- sexually exploring things, especially in high school. Actually, because I think once you get to college, it's a different world and if you don't have some kind of knowledge beforehand, it's kind of drowning when you get there. And it's a hard enough transition to make just academically and socially into college that, if sexually you have absolutely no experience or very little experience that is just an added transition on. And that's, I mean, I had experience coming in so maybe it's not as hard as I think it would be. But I think it's definitely important to get some sort of experience when you're in high school.

The experiences to avoid and explore fall into two categories. In the first category are warnings that sexual activity at an early age brings a great deal of emotional pain that can be eliminated by avoiding sexual activity. Additionally, the advice that boys cannot

be trusted reflects deceitful experiences that disrupt the development of trusting relationships. The second category, experiences to explore, presents a more positive perspective that sexuality is a normal part of development. It is described as part of sexual identity that can be enjoyable when approached with information and openness. The information from this section can be utilized by healthcare providers and educators in preparing curricular activities for comprehensive sex education programs.

*Make Good Relationship Choices*

Making good relationship choices is a third theme most frequently cited by Euro-American participants. The messages that accompany this theme encourage the adolescent females to consider romantic partners that shared their values and beliefs. Brenda, a 27-year-old African-American, made the following comment about how she chose romantic partners based on her values:

> I didn't think that I would ever date a guy that had never been to college. I was like, no, because I'm going to college and you have to be educated, da-da-da, you know? And so, but really knowing what you expect and knowing what to look for and not to waste your time on stuff that, I mean, just stop wasting your time.

Loretta, a 24-year-old Latina, observes that making a good relationship choice was often a result of patience by both the female and the male. Her advice follows.

> You know, the right guy will come. And if he loves you, he's going to wait and it's just going to happen. And then in a matter of time, you're 15, you're going to be 18. If you want to wait until you're in college, then do it. But go to college!

Her message implies that one needs to avoid pressure to have sex and if your partner respects your desire, he will wait too. Additionally, she adds that attending college should be a personal goal that is more important than having sex.

Ally, a 21-year-old American Indian, stressed the importance of valuing oneself when making decisions about relationships. She gave a message that warned her younger sister to choose a partner that she could trust because she would be the one to shoulder the consequences:

> I would - this is something I would always warn my sister- no one is ever as important as you. And that's kind of selfish when you say it. I just always thought, no boy, no man is important enough for you to throw your life away. That's just kind of how I always thought. Because, you know, when that guy gets mad or when you do something he doesn't like, he's going to leave. Not necessarily maybe, but who are you going to have? Yourself. You know, you can only fully trust yourself and that's just how I-maybe because of the way I was brought up or the people I was brought up around- I don't trust people easily. That's what I always told her. No one is ever important as yourself. You need to think of yourself because you never know what that person is going to do to you or might say about you. Or, if you end up pregnant, are they going to leave or are they going to stay?

Camile, a 20-year-old Euro-American, suggested making wise relationship choices based on applying the values taught by parents.

> No guy should expect anything from you and you shouldn't feel obligated to give it to him. And it needs to mean something to you. And it's a gift and that kind of a mentality was something that we were always raised with so … it's never an obligation.

Although this theme was about making good partner choices in romantic relationships, it also included the message to value yourself in the relationship and not to relinquish your power. The literature emphasizes the importance of balancing power in relationships. By emphasizing the need to choose how to behave in relationships, the participants were encouraging their sisters to seek equal power in a relationship.

*Take Responsibility for the Consequences of One's Actions*

The fourth and final theme to emerge from the interviews was that one must assume responsibility for the consequences of one's actions. Latinas were the ones who

were most vocal about this theme. In the advice associated with theme, adolescent females are warned that the consequences of sexual activity can be very costly. They warned of pregnancy, child care responsibility, STDs, and emotional pain. They want to ensure that their little sisters understood that pregnancy would end their carefree lives.

Bernie, a 26-year-old African-American, advised her little sister to avoid sexual activity until she was prepared for any unwanted outcomes.

> Make sure they are mature enough to handle all the consequences that come along with having sex, because there's a lot. Pregnancy, STDs, emotional, all kinds of emotional stress. You have to actually be able to handle and deal with what comes along with it and it's a lot.

Linda, a 22-year-old Latina, discussed the impact of teen pregnancy on her own life. She emphasized the need to be responsible for her own decisions by becoming responsible for another's life.

> First, I mean, I guess I would tell her my life so she'd know what happened to me. And that it's not easy, especially at 14 years old. It's not easy. Even if you have support from, I mean like economically, it's not the same because you don't know. Now there's somebody there that you need to watch out for. It's not only just you anymore. And I would tell her my life and I would tell, if I was able to take some time back, I would not have done it. I mean that's not saying I regret having my kids.

Karen, a 25-year-old Euro-American, gave an unusual perspective that was not based on her own life story. Unfortunately, she did not offer insight as to how she became so mindful of the possible negative outcomes of risky sexual behavior:

> I think a lot of kids don't realize, because they're just kids themselves, need to know how expensive they are. I think if that's one thing that they realize and can see, that having a child, it's not about sex or is it about what happens after sex? Because I think that's where the fine line is. We make such a big deal of let's don't have sex, don't do this, blah blah blah blah, when that makes them curious about it. And they want to do it even more and since it looks good on TV. They're having a good time like this beautiful fun thing because it's not all that glorious. It can be. I think that really in the end, talking about STDs and those kinds of things . . . the major thing is what happens to that kid that you have. I

> mean, not that I think a child can't be raised happily outside of a marriage union. But I think that there's a lot of other factors that can come into play, like economically, financially. What kind of services do these kids get. So I think a lot of that does have to do with it. The experience I've had was like, just babysitting and having to take care of kids. I'm ready to give those kids back. I love to play with kids but I love to do it because I get to give them back at the end of the day.

Out of the participants who talked about being willing to accept the responsibilities associated with risky sexual behavior, most of them focused on pregnancy requiring the greatest responsibility. Specifically, they warned of the difficulty of being responsible for another life, how it limited them from feeling carefree, and the financial burden it imposed.

The advice to younger sisters' section reflected participants' beliefs about how to reduce the difficulties adolescent females experience on their journey to sexual identity development and improvement in their romantic relationships.

## Summary

Today's youth are bombarded with sexual messages and sexual pressures that increase with new technologies every day. Although puberty is a time of sexual awakening, romantic relationships that begin in early adolescence evolve without the benefit of cognitive development that is needed to make good decisions. These relationships can result in pregnancy, STDs and emotional pain that ultimately become the burden of the adolescent female.

My research explored how adolescent females make decisions in romantic relationships. I gathered data about family, peer groups, and school performance to explore the social context in which adolescent sexual identity is developed. It was also deemed important to examine whether, under the circumstances, sex education was

taught and who was available to engage in frank and informed discussion of sexuality with the adolescent females.

The majority of my participants learned about reproduction in the school system. However, these programs often lacked information about contraception and prophylactics. No program contained a component to assist with relationship building. Considering the deficiencies in the school sex education programs, the participants were asked with whom they discussed reproduction. The majority belonged to a peer group and discussed their romantic experiences with each other. Most believed that their peers were sexually active and their behavior conformed to what they believed was their peer group behavior with rare exception. When asked if there was an adult available for discussion of reproduction, many said no.

However, from those who were raised with family support, many aspired to find a romantic relationship similar to parents, aunts, and/or uncles that they admired. In fact, the majority, in spite of a strong or weak nuclear family, reported having a significant relationship with aunts, uncles, and grandparents who were described as confidants, advisors, and role models. All contributed to building the self-esteem of the adolescent.

For those who were encouraged to be independent thinkers, they exhibited less risky behavior in their journey through adolescence. When the participants described the strengths and weaknesses of their own journey, their messages encouraged young women to develop a sense of independence before becoming romantically involved. All advice centered on the need to development self before entering into romantic relationship. The underlying assumption of this message is that this level of maturity

does not develop in early adolescence, so serious romantic involvement should not occur until later in adolescence.

We are living in a time where families are struggling to survive. Many are single- parent households which have little time and fewer resources than years gone by. It is in this climate where family relationships are stressed which can contribute to a lack of communication about reproduction and romantic relationships. In my study, I discovered that even under the best of conditions, reproduction may not be spoken about in the nuclear family. These conditions support the need for adolescents to learn about sex education from sources outside of the family. Although the school system is the most assessable place to teach comprehensive sex education, health care providers can also play a more active role in educating adolescents about sexual issues. Health care providers must be proactive in the dissemination of factual information including the discussion of risks and benefits in a nonjudgmental setting.

These conditions support the need to improve the sex education curriculum in our schools. Comprehensive sex education programs need to teach more than the mechanics of reproduction, contraception, and protection from STDs. The programs need to teach life skills appropriate for building healthy adolescent romantic relationships. Chapter VI will discuss the major findings and make recommendations to policymakers to improve the developmental outcomes of romantic relationships for adolescent females. The goal is to improve adolescent decision-making resulting in reduced teen pregnancy, STDs, and better romantic relationships during adolescence and, hopefully, throughout a lifetime.

# CHAPTER VI – CONCLUSIONS

The purpose of this dissertation is to identify factors that motivate adolescent females' romantic behaviors and decision-making. The goal of the study is to use these factors to suggest strategies to parents, educators, and health professionals to support and encourage healthy adolescent romantic behavior in order to avoid teen pregnancies, STDs, and unnecessary emotional pain. A qualitative methodological approach was used to accomplish this goal, which differs significantly from many previous quantitative studies in the field. This chapter constitutes a summary of the major findings and implications for health educators, healthcare providers and policymakers. The findings will be discussed from the perspective of a call for change in national government policy and for change in the professional approach used by health educators and healthcare providers delivering services to adolescents and their families.

My study accepted the premise from other scholars that sexual awareness and development are normal components of the developmental process for adolescents. One would expect that, due to this natural order, adolescents would be supported in their sexual development. However, as numerous studies, including mine indicate that lack of support from parents, schools, and health professionals appears to have an inverse relationship to the number of unwanted sexual outcomes in adolescents.

The 28 interviews conducted for this study produced a vast amount of data. While each participant's story was informative and useful on its own account, this project attempted to find similarities and differences within and between groups. My analysis focused on four major topics of interest: 1) the effect of sexual activity in early

adolescence, 2) the influence of familial relationships, 3) the role of peer groups, and 4) the power of sex education.

Adolescent development theory states puberty is a time for sexual awakening in adolescents. Unfortunately, while sexual awakening is occurring, cognitive development is still taking place and the ability to think abstractly and consider long-term consequences is not yet established. Sexual intercourse during early puberty, before abstract thinking is developed, results in riskier sexual outcomes (Fonseca & Greydanus, 2007). My research concurred that teen pregnancy occurs most frequently when sexual activity begins in early adolescence.

In early adolescence, close parental monitoring, or strict parenting, was a protective measure for teen pregnancy and/or risky behavior, both in the literature and in my study population. Although all adolescents need monitoring in early adolescence, my findings suggest that Latinas participate in serious romantic relationships earlier than the Euro-Americans, African-Americans, and American Indians. Hence, health educators should encourage all parents and, especially Latinos to engage in more monitoring of behavior during early adolescence with gradually permitting them more freedom in romantic behavior as their abstract thinking improves.

Strong mother-daughter relationships are reported to reduce risky sexual behavior across all cultures. In my research, only one-third of the participants reported having a strong mother-daughter relationship while two-thirds of the participants reported that they did not have a strong relationship with their mother. Although a strong mother-daughter relationship is considered a protection from risky behavior, it did not insure that romantic and sexual topics would be discussed.

Frequently participants named extended family members as influencing their romantic and sexual development. Aunts, uncles, and grandparents filled the role of teacher and mentor. Extended family, in my findings, frequently provided support to African-Americans adolescents. There is very little research exploring relationships with extended family and how it supports adolescent romantic development. Further studies need to be performed to identify specific influences extended families have on adolescent decision-making. Additionally, healthcare providers and educators should utilize the extended family relationships when working with adolescent females regarding reproduction and romantic relationships.

The discussion of romantic behavior with peers influences the sexual development and decision-making in romantic relationships. There was more emphasis on peer group participation by Euro-Americans and African-Americans than Latinas and American Indians. My research results indicated that most adolescents took a cue from their peers in modeling their romantic behavior. Additionally, a majority of the participants perceived that their peers were sexually active and they behaved similarly. In my opinion, comprehensive sex education could be improved by utilizing peer groups for Euro-Americans and African-Americans. American Indians and Latina groups have less involvement with peers suggesting that peer group programs may not be the most effective method of delivery.

The majority of participants learned about reproduction in school. Only one of these participants reported a comprehensive sex education program in her school. The others reported that school curricula contained information about menstrual cycles and reproductive biology, but excluded information about birth control or prophylactic

methods of protection to prevent STDs. The lack of a comprehensive sex education curriculum compromises adolescent females' ability to make informed decisions in romantic relationships.

This research is compatible with prior research indicating that adolescents are uninformed about healthy sexual development and safe-sex practices. Lack of comprehensive sex education in the school, combined with uninformed conversations about sexuality with healthcare providers and other trusted adults, leaves our adolescent females unprepared to manage romantic relationships, resulting in risky sexual behavior and significant emotional and physical pain. Unfortunately, both a cultural and political change will need to take place in order to guarantee the information flow to adolescent females.

## Political Policy

Although the discussion of adolescent sexuality in the family may not improve quickly due to cultural underpinnings, policy changes to improve the sex education programs in schools can happen quickly and are already occurring in some states. Nearly half of all states have refused some type of funding related to "Abstinence-Only" sex education programs (Sexuality Information and Education Council of the United States, 2007a). Thirty-five states, including Oklahoma, mandate STD/HIV education but provisions requiring parental consent and information about abstinence or contraception are state options.

Oklahoma does not require parental consent to attend STD/HIV education, but it does allow parents the option to keep their child from attending the class. Oklahoma requires that abstinence and contraception have to be covered in the sex education

curriculum. Although STD/HIV education is mandated in the Oklahoma school system, sex education, which is much more comprehensive, is not (Guttmacher Institute, 2008c). The lack of mandated sex education may be the reason that nearly all my participants reported learning very little about reproduction in their schools.

The 2008 presidential and federal congressional elections resulted in an increased democratic majority that historically supports comprehensive sex education and women's reproductive healthcare rights. However, the 2008 state election results in Oklahoma increased a conservative majority. This conservative legislature not only restricts comprehensive sex education but prohibits the use of federal and state monies for abortion, requires parental consent for abortion by a minor, and restricts minors from purchasing over-the-counter emergency contraception. Changes can occur in spite of a conservative state legislature when federal rulings supersede state law.

There is evidence that President Barack Obama supports age-appropriate comprehensive sex education for kids K-12. During the 2007 presidential campaign, he was inaccurately attacked in a smear campaign for authoring a bill to teach comprehensive sex education to kindergarteners (Sweet, 2008). The intent of the bill was to support federal government and/or local school board funding to teach five-year-olds about inappropriate touch using federal and local funding (Murray, 2007). As a senator, President Barack Obama supported age-appropriate sex education funding by the federal government in the school system.

In addition, President Barack Obama proclaims that he will assess current programs for effectiveness and eliminate those that are ineffective (Berkowitz, 2008, November 12). Abstinence-only sex education programs are ineffective and, therefore,

under heavy scrutiny. Congressman Henry Waxman (D-CA), chair of the House Committee on Oversight and Government Reform, conducted a hearing on the effectiveness of abstinence-only-until-marriage programs. The hearing concluded that, after 12 years and $1.5 billion dollars of federal spending, there is no evidence that the abstinence-only programs were effective (Waxman, 2008).

The direction of sex education could change rapidly if the current budget, of nearly $200 million annually, that supports abstinence-only education were channeled into comprehensive sex education programs. It is my opinion that adolescents would immediately benefit from comprehensive sex education programs. The change could occur quickly due to the availability of well-developed, easily accessible guidelines and curriculum. In response to the dilemma of schools and educators struggling to develop appropriate sex education programs, one organization, the Sexuality Information and Education Council of the United States (SIECUS), has developed and published the guidelines for comprehensive sex education targeting children and adolescents from kindergarten through 12$^{th}$ grade. The guidelines were originally developed by a group of leading educators, health professionals, and representatives from national organizations in 1991 and are currently in their third edition. They include the following six key concepts: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture (Sexuality Information and Education Council of the United States, 2008). Each concept is leveled for age-appropriate delivery. Although the SIECUS program is a guideline and not a curriculum, there are multiple online available resources to customize programs to best fit the targeted audiences. The programs are

age-appropriate and could be adapted to peer groups and families for additional effectiveness.

Another option for teaching comprehensive sex education to adolescents would be to include parents or an extended family member that wanted to be involved in the romantic development of the adolescent. It is my opinion and that of Klein and Ackerman, (1995) adult family members want to be involved with their adolescent's romantic and sexual development, but few adults know how to communicate about romantic relationships and sexual activity to their adolescents in an effective manner.

Comprehensive sex education programs could take place in schools, community youth centers, and churches. The curriculum could target families and peer groups. Parents who are interested could be taught how to teach their children age-appropriate sex education. Ideally, the programs would start in early childhood to build the foundation needed for discussions about romantic and sexual behavior in adolescence. Peer groups could be used to establish healthy relationships needed to build the characteristics needed to support romantic relationships.

Comprehensive Sex Education programs would include a life skills agenda that supports the development of the whole adolescent. As the research findings indicate, girls who are encouraged to set goals and learn to make decisions that will support their goals become independent and self-confident. These are the same skills needed to make good decisions in romantic and sexual relationships.

Comprehensive sex education is a good place to begin making changes for healthier adolescent romantic relationships, but it is only one of many reproductive

issues that this new administration can influence to improve the overall status of women's health.

Many organizations are optimistic about the new administration and the opportunities to change some of the backward movement that have taken place in the Bush Administration. The National Organization for Women (NOW) has proposed a Feminist Action Agenda. The agenda for Reproductive Rights and Sexual Health addresses the following issues related to my research.

- Halt funding for Abstinence Education and support medically accurate comprehensive sex education.
- Reduce unintended pregnancy by increasing Title X Family Planning funding. This effort would reinstate affordable, accessible contraception to low income females of reproductive age.
- Reject policies that allow pharmacists to refuse to fill contraceptive prescriptions.
- Require insurance companies that cover prescription medications to cover birth control.
- Withdraw the age restriction on over-the-counter emergency contraception (National Organization for Women, 2008).

In addition, the Obama-Biden Transition Project outlines a first 100-day action plan that includes all the above issues addressed by NOW (Obama-Biden Transition Project, 2008). These plans indicate that there is a high level of confidence that the new administration will improve the reproductive health options for females. Health care providers need to be proactive in exploring reproductive issues with adolescent females.

They are in key positions to disseminate complete and accurate information. Comprehensive sex education, combined with better access to reproductive health care, could reduce the number of unwanted pregnancies and STDs. Starting with the information taught in comprehensive sex education and better access to reproductive health care, this country may be able reduce the number of unwanted pregnancies and STDs.

While this study has shown the importance and value in comprehensive sex education programs, it has also shown the significant influence adults and peers have in directing adolescents toward healthy decision-making in romantic relationships. Guidelines for the parental instruction and monitoring are needed. Inclusion of extended family members needs to be offered to adolescents and families who would benefit from building on important family relationships. Adolescent peer groups should be utilized for two reasons: 1) adolescents rely on each other to normalize their behavior; and 2) to dispel potential myths about reproduction and peer sexuality. Cultural factors need to be considered for both adult and peer participation

Future research needs to be conducted to evaluate the effectiveness of the above strategies. Additionally, a similar study needs to be conducted with young or adolescent males. Comprehensive sex education programs should address the needs of adolescent males and females when the goal is to reduce teen pregnancy, and STDs, and to improve their romantic relationships.

Adolescence is a confusing and challenging time for a female and her family. Better access to health care, having providers who are attuned to adolescent reproductive needs, and comprehensive sex education programs could educate and

support the adolescent female and her family by teaching her how to build better relationships within her family and in forming future romantic relationships. Hopefully, this is a starting place for reducing unwanted pregnancies, STDs, and the emotional pain associated with poor romantic decisions.

In my next research study, I would like to focus on adolescent females ranging in age from 13-17 years of age. Using the same methodology, I might add questions exploring participants' use of the internet, text messaging, and text images. I would contrast and compare data from the two studies as participants represent two different age groups.

My review of the literature and findings in the dissertation indicate that some adolescent girls are taught that boys are not trustworthy. This approach does not support adolescent females' development of healthy romantic relationships. Another related study that I might consider would be on adolescent male romantic relationships. The data would complement my current study on adolescent females and might also have an applied dimension focusing on comprehensive sex education for male and female adolescents to assist them in building healthy romantic relationships. My research has been confined to the state of Oklahoma. I would encourage researchers elsewhere to explore similar topics in their respective states to broaden our knowledge base about this important topic.

REFERENCES


Abrams, L. S. (2003). Contextual variations in young women's gender identity negotiations. *Psychology of Women Quarterly, 27*(1), 64-74.

Adams, M., Jasani, B., & Fiander, A. (2007). Human papilloma virus (HPV) prophylactic vaccination: Challenges for public health and implications for screening. *Vaccine, 25*(16), 3007-3013.

American Association of Physical Anthropologists. (1996). AAPA Statement on biological aspects of race. *American Journal of Physical Anthropology, 101*, 569-570.

American College of Obstetricians-Gynecologists (2006). ACOG Committee Opinion. Evaluation and management of abnormal cervical cytology and histology in the adolescent. *Obstetrics & Gynecology, 107*(4), 963-968.

American Experience. (2002). Timeline: The pill. Retrieved July 28, 2008, from http://www.pbs.org/wgbh/amex/pill/timeline/index.html

American Society of Plastic Surgeons. (2007a). Cosmetic plastic surgery procedures for ethnic patients up 13 percent in 2007. Retrieved August 29, 2008, from http://www.plasticsurgery.org/media/press_releases/Cosmetic-Plastic-Surgery-Procedures-for-Ethnic-Patients-Up-13-Percent-in-2007.cfm

American Society of Plastic Surgeons. (2007b). Cosmetic surgery age distribution. Retrieved August 29, 2008, from http://www.plasticsurgery.org/media/statistics/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29430

Annas, G. J. (2007). Health law, ethics, and human rights: The Supreme Court and abortion rights. *The New England Journal of Medicine, 356*(21), 2201-2207.

Archer, L., Halsall, A., & Hollingworth, S. (2007). Inner-city femininities and education: 'Race,' class, gender and schooling in young women's lives. *Gender & Education, 19*(5), 549-568.

Aronowitz, T., & Munzert, T. (2006). An expansion and modification of the information, motivation, and behavioral skills model: implications from a study with African American girls and their mothers. *Issues in Comprehensive Pediatric Nursing, 29*(2), 89-101.

Aten, M. J., Siegel, D. M., Enaharo, M., & Auinger, P. (2002). Keeping middle school students abstinent: outcomes of a primary prevention intervention. *Journal of Adolescent Health, 31*(1), 70-78.

Attorney General Opinion (1986). Minors cannot be denied services according to the original intent of Title 10 monies.

Bailey, B. L. (1988). *From front porch to back seat: Courtship in twentieth-century America*. Baltimore: Johns Hopkins University Press.

Baril, M. E., Crouter, A. C., & McHale, S. M. (2007). Processes linking adolescent well-being, marital love, and coparenting. *Journal of Family Psychology, 21*(14), 645-654.

Basow, S. A. (2006). Gender role and gender Identity development. In J. Worell & C. D. Goodheart (Eds.), *Handbook of Girls' and Women's Pschological Health* (pp. 242-261). Oxford: University Press.

Bay-Cheng, L. Y., & Lewis, A. E. (2006). Our "ideal girl": Prescriptions of female adolescent sexuality in a feminist mentorship program. *Journal of Women and Social Work, 21*(1), 71-83.

Bazargan, M., & West, K. (2006). Correlates of the intention to remain sexually inactive among underserved Hispanic and African American high school students. *Journal of School Health, 76*(1), 25-32.

Beisel, N., & Kay, T. (2004). Abortion, race, and gender in nineteenth-century America. *American Sociological Review 69*(4), 498-518.

Berkowitz, B. (2008, November 12). Faith-based initiatives in the Obama administration? *Dissident Voice*. Retrieved December 10, 2008, from http://www.dissidentvoice.org/2008/11/faith-based-initiatives-in-the-obama-administration/

Bill, H., Moffitt, T. E., Caspi, A., Langley, J., & Silva, P. A. (1994). On the 'remembrance of things past': A longitudinal evaluation of the retrospective method. *Psychological Assessment, 6*(2), 92-101.

Blum, R. W., Beuhring, T., Shew, M. L., Bearinger, L. H., Sieving, R. E., & Resnick, M. D. (2000). The effects of race/ethnicity, income, and family structure on adolescent risk behaviors. *American Journal of Public Health, 90*(12), 1879-1884.

Blumenthal, P. (2003). The federal ban on so-called "partial-birth abortion" is a dangerous intrusion into medical practice [Electronic Version]. *Medscape, 5*(2), 2. Retrieved from http://www.medscape.com/viewarticle/457581

Borawski, E. A., Levers-Landis, C. E., Lovegreen, L. D., & Trapl, E. S. (2003). Parental monitoring, negotiated unsupervised time, and parental trust: the role of

perceived parenting practices in adolescent health risk behaviors. *Journal of Adolescent Health, 33*(2), 60-70.

Boston Women's Health Book Collective (1998). *Our bodies, ourselves for the new century: A book by and for women*: New York: Simon & Schuster.

Brabeck, M. M., & Brabeck, K. M. (2006). Women and relationships. In J. Worell & C. D. Goodheart (Eds.), *Handbook of Girls' and Women's Psychological Health* (pp. 208-217). New York: Oxford University Press.

Bryder, L. (2008). Debates about cervical screening: An historical overview. *Journal of Epidemiology & Community Health, 62*(4), 284-287.

Bussey, K., & Bandura, A. (1999). Social cognitive theory of gender development and differentiation. *Pschological Review, 106*(4), 676-713.

Cacioppo, J. T. (2002). *Foundations in social neuroscience*. Cambridge: MIT Press.

Call, K., Mortimer, J. T., & Shanahan, M. (1995). Helpfulness and the development of competence in adolescence. *Child Development, 66*, 129-138.

Call, K., Riedel, A. A., Hein, K., McLoyd, V., Petersen, A., & Kipke, M. (2002). Adolescent health and well-being in the twenty-first century: A global perspective. *Journal of Research on Adolescence, 12*(1), 69-98.

Caron, S. M. (1998). Birth control and the black community in the 1960s: Genocide or power politics? *Journal of Social History, 31*(2), 26.

Carpenter, L. M. (2005). *Virginity lost: An intimate portrait of first sexual experiences*. New York: New York University Press.

Carroll, L., & Anderson, R. (2002). Body piercing, tattooing, self-esteem, and body investment in adolescent girls. *Adolescence, 37*(147), 627-637.

Cavanagh, S. E. (2007). The social construction of romantic relationships in adolescence: Examining the role of peer networks, gender, and race. *Sociological Inquiry, 77*(4), 572-600.

Cavanagh, S. E., Riegle-Crumb, C., & Crosnoe, R. (2007). Puberty and the education of girls. *Social Psychology Quarterly, 70*(2), 186-199.

Center for Disease Control and Prevention (2008). Nationally Representative CDC Study Finds 1 in 4 Teenage Girls Has a Sexually Transmitted Disease. *2008 National STD Prevention Conference Confronting Challenges, Applying Solutions*. Retrieved from

http://www.cdc.gov/stdconference/2008/media/release-11march2008.htm. doi:http://www.cdc.gov/stdconference/2008/media/release-11march2008.htm

Centers for Disease Control and Prevention. (2008a). HPV vaccine information for young women. Retrieved February 10, 2009, from http://www.cdc.gov/std/Hpv/STDFact-HPV-vaccine.htm#hpvvac1

Centers for Disease Control and Prevention. (2008b). Nationally representative CDC study finds 1 in 4 teenage girls has a sexually transmitted disease [Electronic Version]. *2008 National STD Prevention Conference: Confronting Challenges, Applying Solutions* Retrieved March 9, 2009, from http://www.cdc.gov/stdconference/2008/media/release-11march2008.htm

Centers for Disease Control and Prevention. (2002). 2002 National STD Surveillance Report: STDs in adolescents and young adults. Retrieved January 8, 2009, from http://www.cdc.gov/std/stats/default.htm

Centers for Disease Control and Protection. (2008). State cancer facts. Retrieved August 21, 2008, from http://apps.nccd.cdc.gov/statecancerfacts/Table.aspx?Group=5f&TableType=INCI&SelectedState=Oklahoma

Chavkin, W. (2001). Sex, Lies, and Silence: Reproductive Health in a Hostile Environment. *American Journal of Public Health, 91*(11), 1739-1741.

Christopher, S. (2005). Recommendations for conducting successful research with Native Americans. *Journal of Cancer Education, 20*(1 Suppl), 47-51.

Coburn, N., Fulton, J., Pearlman, D. N., Law, C., DiPaolo, B., & Cady, B. (2008). Treatment variation by insurance status for breast cancer patients. *Breast Journal, 14*(2), 128-134.

Collins, W. A. (2003). More than Myth: The Developmental Significance of Romantic Relationships During Adolescence. *Journal of Research on Adolescence 13*(1), 1-24.

Connolly, J., Craig, W., Goldberg, A., & Pepler, D. (2004). Mixed-gender groups, dating, and romantic relationships in early adolescence. *Journal of Research on Adolescence, 14*(2), 185-207.

Connolly, J., Furman, W., & Konarski, R. (2000). The role of peers in the emergence of heterosexual romantic relationships in adolescence. *Child Development, 71*(5), 1395-1408.

Crutsinger, M. (2009, February 26). Obama budget moves toward universal health care. Retrieved March 23, 2009, from

http://www.google.com/hostednews/ap/article/ALeqM5hxNsSwJHL9EJObAjj4qPX_ER166gD96JA3Q80

Culwell, K. R., & Feinglass, J. (2007a). The association of health insurance with use of prescription contraceptives. *Perspectives on Sexual & Reproductive Health, 39*(4), 226-230.

Culwell, K. R., & Feinglass, J. (2007b). Changes in prescription contraceptive use, 1995-2002: The effect of insurance status. *Obstetrics & Gynecology, 110*(6), 1371-1378.

Darling-Hammond, L. (2007). Evaluating 'no child left behind'. *The Nation*. Retrieved from http://www.thenation.com/doc/20070521/darling-hammond

Debold, E. W. M., & Malavé, I. (1993). *Mother daughter revolution: From betrayal to power*. Reading, Mass.: Addison-Wesley Pub.

DeMinzi, M. C. R. (2006). Loneliness and depression in middle and late childhood: The relationship to attachment and parental styles. *The Journal of Genetic Psychology, 167*(2), 189-210.

Denny, G., & Young, M. (2006). An evaluation of an abstinence-only sex education curriculum: An 18-month follow-up. *Journal of School Health, 76*(8), 414.

Donaldson-James, S. (2008). Study reports anal sex on rise among teens: Lack of sex education, virginity pledges, ignorance contribute to risky behavior. *Health.* Retrieved December 10, 2008, from http://abcnews.go.com/Health/Story?id=6428003&page=1

Doswell, W. M., Yookyung, K., Braxter, B., Taylor, J., Kitutu, J., & Yu-Yun, A. (2003). A theoretical model of early teen sexual behavior: What research tells us about mother's influence on the sexual behavior of early adolescent girls. *The Journal of Theory Construction and Testing, 7*(2), 56-60.

Eitle, D. (2006). Parental gender, single-parent families, and delinquency: Exploring the moderating influence of race/ethnicity. *Social Science Research, 35*(3), 727-748.

Erdahl, K. J., & Holten, K. B. (2006). Emergency contraception care. *The Journal of Family Practice, 55*(12), 1073-1075.

Feldmann, J., & Middleman, A. B. (2002). Adolescent sexuality and sexual behavior. *Current Opinion in Obstetrics & Gynecology, 14*(5), 489-493.

Fine, M. (1988). Sexuality, schooling, and adolescent females: The missing discourse of desire. *Harvard Educational Review, 58*(1), 29-53.

Fine, M., & McClelland, S. I. (2006). Sexuality education and desire: Still missing after all these years. *Harvard Educational Review, 76*(3), 297-338.

Fonseca, H., & Greydanus, D. E. (2007). Sexuality in the child, teen, and young adult: Concepts for the clinician. *Primary Care: Clinics in Office Practice, 34*(2), 275-292.

Freking, K. (2007). Study: Abstinence classes don't stop sex. *Yahoo News.* April 14, 2007. Retrieved March 10, 2008, from http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2007/04/13/national/w092103D81.DTL&feed=rss.news

Freking, K. (2008, June 24). States turn down U.S. abstinence education grants. *San Fransisco Chronicle*. Retrieved July 5, 2008, from http://www.sfgate.com/cgi-bin/article.cgi?file=/n/a/2008/06/24/national/w105946D40.DTL

Friedlander, L., Connolly, J., Pepler, D., & Craig, W. (2007). Biological, Familial, and Peer Influences on Dating in Early Adolescence. *Archives of Sexual Behavior 36*(6), 821-830.

Garrow, D. (1998). *Liberty and sexuality: The right to privacy and the making of Roe v.* Wade, updated. Berkeley: University of California Press.

Gibbs, G. R. (2002). *Qualitative analysis: Exploration with NVivo*. Burmingham: Open University.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, Mass.: Harvard University Press.

Gilligan, C. (1991). Reframing resistance. In C. Gilligan, A. G. Rogers & D. L. Tolman (Eds.), *Women, Girls & Psychotherapy: Reframing Resistance*. New York: Haworth Press.

Ginsburg, F. D. (1989). *Contested lives: The abortion debate in an American community*. Berkeley: University of California Press.

Goldsmith, K. A., Kasehagen, L. J., Rosenberg, K. D., Sandoval, A. P., & Lapidus, J. A. (2008). Unintended childbearing and knowledge of emergency contraception in a population-based survey of postpartum women. *Maternal & Child Health Journal, 12*(3), 332-341.

Gordon, L. (1986). Who is frightened of reproductive freedom for women and why? Some historical answers. *Frontiers: A Journal of Women Studies, 9*(1), 23-26.

Greene, M. (2007). The intimidation of American physicians - banning partial-birth abortion. *New England Journal of Medicine, 356*(21), 2128-2129.

Guttmacher Institute. (2008a). Facts on induced abortion in the United States. Retrieved August 1, 2008, from http://www.guttmacher.org/pubs/fb_induced_abortion.html

Guttmacher Institute. (2008b). State facts about abortion: Oklahoma. Retrieved August 1, 2008, from http://www.guttmacher.org/pubs/sfaa/oklahoma.html

Guttmacher Institute. (2008c). State policies in brief: Sex and STI/HIV education. Retrieved December 10, 2008, from http://www.guttmacher.org/statecenter/spibs/index.html

Halpern, C. T., Kaestle, C. E., & Hallfors, D. D. (2007). Perceived physical maturity, age of romantic partner, and adolescent risk behavior. *Prevention Science, 8*(1), 1-10.

Harris, L., Oman, R. F., Vesely, S. K., Tolma, E. L., Aspy, C. B., Rodine, S., et al. (2007). Associations between youth assets and sexual activity: Does adult supervision play a role? *Child Care, Health and Development, 33*(1), 448-454.

Hatch, M., Von Ehrenstein, O., Wolff, M., K. Greduld, A., & Einhorn, F. (1999). Using qualitative methods to elicit recall of a critical time period. *Journal of Women's Health, 8*(2), 269-277.

Haynie, D. L. (2003). Contexts of risk? Explaining the link between girls' pubertal development and their delinquency involvement. *Social Forces 82*(1), 355-397.

Hellerstedt, W. L., Peterson-Hickey, M., Rhodes, K. L., & Garwick, A. (2006). Environmental, social, and personal correlates of having ever had sexual intercourse among American Indian youths. *American Journal of Public Health, 96*(12), 2228-2233.

Henson, R. M., Wyatt, S. W., & Lee, N. C. (1996). The National Breast and Cervical Cancer Early Detection Program: A comprehensive public health response to two major health issues for women. *Journal of Public Health Management & Practice, 2*(2), 36-47.

Hernandez, T. (1997, July 15). Race vs. ethnicity. *The New York Times*. Retrieved March 12, 2009, from http://www.nytimes.com/1997/07/15/opinion/l-race-vs-ethnicity-136301.html

Higgins, J. A., & Hirsch, J. S. (2008). Pleasure, power, and inequality: Incorporating sexuality into research on contraceptive use. *American Journal of Public Health, 98*, 1803-1813.

Hoffman, S. (2006). By the numbers: The public costs of teen childbearing. Retrieved July 10, 2008, from http://www.thenationalcampaign.org/costs/pdf/report/BTN_National_Report.pdf

hooks, B. (2000). *Feminism is for everybody: Passionate politics*. Cambridge: South End Press.

Horn, L. (2006). Placing college graduation rates in context: How 4-year college graduation rates vary with selectivity and the size of low-income enrollment. Retrieved August 29, 2008, from http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2007161

Howell, M. (2007). The history of federal abstinence-only funding. *Advocates for Youth.* Retrieved June 4, 2008, from http://www.advocatesforyouth.org/publications/factsheet/fshistoryabonly.pdf

Hutchinson, M. K., Jemmott, J. B., 3rd, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: a prospective study. *Journal of Adolescent Health, 33*(2), 98-107.

Illegal Abortion on Unemancipated Minor - Criminal and Civil Liability. 49th Okla. Leg., §63-1-740.4(2006).

Illegal Abortion on Unemancipated Minor - Criminal and Civil Liability. 50th Okla. Leg., §63-1-740.4b(2007).

Jacobson, K. C., & Crockett, L. J. (2000). Parental monitoring and adolescent adjustment: An ecological perspective. *Journal of Research on Adolescence, 10*(1), 65-97.

Johnson, J. (2008). Abortion history. Retrieved March 3, 2009, from http://womenshistory.about.com/od/abortionuslegal/a/abortion.htm

Jones, C. J., Leung, N., & Harris, G. (2006). Father-daughter relationship and eating psychopathology: The mediating role of core beliefs. *British Journal of Clinical Psychology, 45*(3), 319-330.

Kaiser, E. (2009). Economist see longest recession since WWII. *Reuters.* Retrieved February 9, 2009, from http://www.reuters.com/article/newsOne/idUSTRE5090QL20090110

Kelly, J. (2001). Dads and daughters: Grassroots advocacy. *Pediatric Nursing, 27*(4), 391-393.

Klein, L. F., & Ackerman, L. A. (1995). *Women and power in native North America*. Norman: University of Oklahoma Press.

Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health, 42*(4), 344-351

Kornreich, J. L., Hearn, K. D., Rodriguez, G., & O'Sullivan, L. F. (2003). Sibling influence, gender roles, and the sexual socialization of urban early adolescent girls. *Journal of Sex Research, 40*(1), 101-110.

Kuhn, C. G. (2007). An EPICC oversight: Why the current battle for access to contraception will not help reduce unintended pregnancy in the U.S. *Health Matrix, 17*(2), 347-375.

La Plante, J. (2006). Empower patients, not bureaucrats. *Perspective.* Retrieved August 19, 2008, from http://www.policyguy.com/pubs/ocpa/EmpowerPatients.pdf

Leaper, C., & Brown, C. S. (2008). Perceived experiences with sexism among adolescent girls. *Child Development, 79*(3), 685-704.

LeCompte, M. D. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research, 52*(1), 31-60.

Lescano, C. M., Brown, L. K., Miller, P. M., & Puster, K. L. (2007). Unsafe sex: Do feelings matter? *Journal of Prevention & Intervention in the Community, 33*(1-2), 51-62.

Levine, J. (2002). *Harmful to minors: The perils of protecting children from sex.* Minneapolis, Minn.: London.

Lifespan. (2008). Teens' failure to use condoms linked to partner disapproval, fear of less sexual pleasure. *ScienceDaily.* Retrieved December 10, 2008, from http://www.sciencedaily.com/releases/2008/09/080909122757.htm

Link, B. G., Phelan, J. C., Miech, R., & Westin, E. L. (2008). The resources that matter: Fundamental social causes of health disparities and the challenge of intelligence. *Journal of Health & Social Behavior, 49*(1), 72-91.

Lofland, J., & Lofland, L. L. (1995). *Analyzing social settings: A guide to qualitative observation and analysis* (3rd ed.). Belmont: Wadsworth.

Lord, A. M. (2004). Naturally Clean and Wholesome. *Social History of Medicine, 173*(3), 423-441.

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2008). Report of APA Task Force on mental health and abortion. Retrieved September 5, 2008, from http://www.apa.org/releases/abortion-report.pdf

Marshall, C., & Rossman, G. (1980). *Designing qualitative research*. Newbury Park: Sage.

Martyn, K. K., & Belli, R. F. (2002). Methods. Retrospective data collection using event history calendars. *Nursing Research, 51*(4), 270-274.

Martyn, K. K., & Hutchinson, S. A. (2001). Low-income African American adolescents who avoided pregnancy: Tough girls who rewrite negative scripts. *Qualitative Health Research, 11*(2), 238-256.

McMillan, J. A. (2006). *Oski's Pediatrics* (4th ed.). Baltimore: Lippincott Williams & Wilkins.

McMurrer, J. (2007, December). Choices, changes, and challenges: Curriculum and instruction in the NCLB era. *A report in the series from the Capital to the Classroom: Year 5 of the No Child Left Behind Act.* Retrieved March 2, 2009, from http://www.cep-dc.org/index.cfm?fuseaction=document.showDocumentByID&nodeID=1&DocumentID=212

Meyer-Bahlburg, H. F., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior, 35*(6), 667-684.

Molina, L. (1999). Human sexuality. *California State University, Northridge.* Retrieved February 2, 2009, from http://www.csun.edu/~vcpsy00h/students/sexual.htm

Morrison-Beedy, D., Carey, M. P., Cote-Arsenault, D., Seibold-Simpson, S., & Robinson, K. A. (2008). Understanding sexual abstinence in urban adolescent hirls. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37*(2), 185-195.

Murray, M. (2007). Obama and sex ed for kids. *MSNBC.* Retrieved December 10, 2008, from http://firstread.msnbc.msn.com/archive/2007/07/19/277886.aspx

National Campaign to Prevent Teen Pregnancy. (2007). With one voice: America's adults and teens sound off about teen pregnancy Retrieved March 30, 2009, from http://www.thenationalcampaign.org/resources/default.aspx

National Cancer Institute. (2007). Screening mammograms: Questions and answers. Retrieved September 5, 2008, from http://www.cancer.gov/cancertopics/factsheet/detection/screening-mammograms

National Cancer Institute. (2008). Cancer advances in focus: Cervical cancer. Retrieved August 21, 2008, from http://www.cancer.gov/Templates/doc.aspx?viewid=CA5EF6E5-F688-4D1C-A64E-E999866BA508

National Institute of Child Health and Human Development. (2007). What is the ADD health study. Retrieved September 9, 2008, from http://www.nichd.nih.gov/health/topics/add_health_study.cfm

National Organization for Women. (2008). NOW's feminist action agenda for 2009 and beyond. Retrieved December 12, 2008, from http://www.now.org/issues/agenda2009.html

National Partnership for Women and Families. (2008). A solution in search of a problem: Revisiting the Title X "Gag Rule" Retrieved August 16, from http://www.nationalpartnership.org/site/DocServer/Gag_Rule_Fact_Sheet_Final_May_2008.pdf?docID=3441

O'Reilly, K. (2005). *Ethnographic methods*. New York: Routledge Taylor & Francis Group.

O'Sullivan, L., & Hearn, K. (2008). Predicting first intercourse among urban early adolescent girls: The role of emotions. *Cognition & Emotion 22*(1), 168-179.

O'Sullivan, L., & Meyer-Bahlberg, H. (2003). African American and Latina inner-city girls' reports of romantic and sexual development. *Journal of Social and Personal Relationships, 20*(2), 221-238.

Obama-Biden Transition Project. (2008). Advancing reproductive rights and health in a new administration. Retrieved December 14, 2008, from http://change.gov/open_government/entry/advancing_reproductive_rights_and_health_in_a_new_administration/

Oklahoma State Department of Health. (2008). Oklahoma Breast and Cervical Cancer Treatment Program. Retrieved August 21, 2008, from http://www.ok.gov/health/Disease,_Prevention,_Preparedness/Chronic_Disease_Service/Cancer_Prevention_Programs_/Oklahoma_Breast_and_Cervical_Cancer_Treatment_Program.html

Oman, R. F., Vesely, S. K., Aspy, C. B., McLeroy, K. R., & Luby, C. D. (2004). The association between multiple youth assets and sexual behavior. *American Journal of Health Promotion, 19*(1), 12-18.

Ozler, S., & Tari, A. (1992). A comparison of the psychological profiles of teenage mothers and their nonmother peers: I. ego. *Adolescence, 27*(105), 193.

Pedlow, C. T., & Carey, M. P. (2004). Developmentally appropriate sexual risk reduction interventions for adolescents: Rationale, review of interventions, and recommendations for research and practice. *Annals of Behavioral Medicine, 27*(3), 172-184.

Philipsen, G. (1992). *Speaking culturally: Explorations in social communication*. Albany: State University of New York Press.

Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research*. New York: Oxford University Press.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., et al. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA: Journal of the American Medical Association, 278*(10), 823-832.

Reynolds, B., & Repetti, R. (2006). Adolescent girls' health in the context of peer and community relationship. In J. Worrell & C. Goodheart (Eds.), *Handbook of Girls' and Women's Psychological Health* (pp. 292-310). Oxford: Oxford University Press.

Roberts, D., & Christenson, P. (2008). *It's not only rock and roll*. Cresskill, N.J.: Hampton Press

Rosenberg, T. J., Raggio, T. P., & Chiasson, M. A. (2005). A further examination of the "Epidemiologic Paradox": Birth outcomes among Latinos. *Journal of the National Medical Association, 97*(4), 550-556.

Rosenfield, A. (1993). Women's reproductive health. *American Journal of Obstetrics and Gynecology, 169*(1), 128-131.

Rowan-Kenyon, H. T. (2007). Predictors of delayed college enrollment and the impact of socioeconomic status. *Journal of Higher Education 78*(2), 188-214.

Ruble, D. N., Taylor, L. J., Cyphers, L., Greulich, F. K., Lurye, L. E., & Shrout, P. E. (2007). The role of gender constancy in early gender development. *Child Development, 78*(4), 1121-1136.

Ryan, B. (1992). *Feminism and the women's movement: Dynamics of change in social movement ideology and activism*. New York, NY: Routledge.

S. 1522, 51st Okla. Leg. § 1210.195.1 (2008).

Saegert, S. C., Adler, N. E., Bullock, H. E. K., Caurce, A. M., Liu, W. M., & Wyche, K. F. (2006). *APA Task Force on Socioeconomic Status (SES)*: American Psychiatric Association.

Sandelowski, M. (2004). Using Qualitative Research. *Qualitative Health Research, 14*(10), 1366-1386.

Sanger, M. (1977). The Turbid Ebb and Flow of Misery. In A. M. Eastman (Ed.), *The Norton Reader* (pp. 43-47). New York: W.W. Norton and Company Inc.

Santelli, J. S., Lowry, R., Brener, N. D., & Robin, L. (2002). The association of sexual behaviors with socioeconomic status, family structure, and race/ethnicity among US adolescents. *American Journal of Public Health, 90*(10), 1582-1588.

Santor, D. A., Messervey, D., & Kusumakar, V. (2000). Measuring peer pressure, popularity, and Conformity in adolescent boys and girls: Predicting school performance, sexual attitudes, and substance abuse. *Journal of Youth and Adolescence, 29*(2), 163-182

SB 1742 (2006). 2nd Session 51st Okla. Leg. *(November, 2008)*

Sexuality Information and Education Council of the United States (2004). The politics of sexuality education. *SIECUS Report, 32*(4).

Sexuality Information and Education Council of the United States. (2007a). Federal abstinence-only-until-marriage funding by state. Retrieved December 14, 2008, from http://www.siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=671&grandparentID=478&parentID=487

Sexuality Information and Education Council of the United States. (2007b). Sexuality education and abstinence-only-until-marriage programs in the states: An overview. Retrieved March 10, 2009, from http://www.siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=668&grandparentID=478&parentID=487

Sexuality Information and Education Council of the United States. (2008). Guidelines for comprehensive sexuality education, Kindergarten through 12th grade. *National Guidelines Task Force.* Retrieved January 5, 2009, from http://www.siecus.org/_data/global/images/guidelines.pdf

Shapiro, A. A. E. (1990). Title X, the abortion debate, and the First Amendment. *Columbia Law Review, 90*(6), 1737-1778.

Sieving, R. E., McNeely, C. S., & Blum, R. W. (2000). Maternal expectations, mother-child connectedness, and adolescent sexual debut. *Archives of Pediatrics & Adolescent Medicine, 154*(8), 809-816.

Sim, T. N., & Koh, S. F. (2003). A domain conceptualization of adolescent susceptibility to peer pressure. *Journal of Research on Adolescence, 13*(1), 57-80.

Simoni, J. M., Sehgal, S., & Walters, K. L. (2004). Triangle of risk: Urban American Indian women's sexual trauma, injection drug use, and HIV sexual risk behaviors. *AIDS & Behavior, 8*(1), 33-45.

Singleton, R. A., Jr., & Straits, B. C. (2005). *Approaches to social research* (4th ed.). New York: Oxford University Press.

Smith, M. (1993). Pediatric sexuality: promoting normal sexual development in children. *Nurse Practitioner, 18*(8), 37-38.

Smokowski, P. R., & Bacallao, M. L. (2006). Acculturation and aggression in Latino adolescents: A structural model focusing on cultural risk factors and assets. *Journal of Abnormal Child Psychology, 34*(5), 659-673.

Smolowe, J. (1991). Gagging the clinics. *Time, 137*(22), 16-17.

Snyder, J., Bank, L., & Burraston, B. (2005). The consequences of antisocial behavior in older male siblings for younger brothers and sisters. *Journal of Family Psychology, 19*(4), 643-653.

Solinger, R. (2005). *Pregnancy and power: A short history of reproductive politics in America*. New York: NYU Press.

Sonfield, A., Alrich, C., & Gold, R. B. (2008). *Public funding for family planning,sterilization and abortion services, FY 1980–2006* New York: Guttmacher Institute.

Spradley, J. P., & McCurdy, D. W. (1988). *The cultural experience: Ethnography in complex society*. Prospect Heights: Waveland Press.

Stack, C. B. (1974). *All our kin: Strategies for survival in a Black community*. New York: Harper Torch Books.

Stein, R. (2008, January 22). As abortion rate drops, use of RU-486 is on rise. *Washington Post*, p. A01. Retrieved January 28, 2008, from http://www.washingtonpost.com/wp-dyn/content/story/2008/01/22/ST2008012200560.html

Stone, D. (2008, March 10, 2009). New Oklahoma law: Women seeking abortions must have ultrasounds against their will. *AlterNet.* Retrieved December 15, 2008, from http://www.alternet.org/reproductivejustice/83454/

Suris, J.-C., Jeannin, A., Chossis, I., & Michaud, P.-A. (2007). Piercing among adolescents: Body art as risk marker--A population-based survey. *The Journal of Family Practice, 56*(2), 126-130.

Sweet, L. (2008, September 10). McCain wrong on Obama and sex education. *Chicago Sun Times*. Retrieved December 10, 2008, from http://blogs.suntimes.com/sweet/2008/09/mccain_wrong_on_obama_and_sex.html

Taylor, J. M., Gilligan, C., & Sullivan, A. M. (1995). *Between voice and silence: Women and girls, race and relationship*. Cambridge: Harvard University Press.

The Associated Press. (2008). Oklahoma ultrasound law challenged. *Truthout.* Retrieved November 3, 2008, from http://www.truthout.org/article/health_101008

The National Campaign to Prevent Teen and Unplanned Pregnancy. (2008). Sex and tech: The results from a survey of teens and young adults. Retrieved January 5, 2009, from http://www.thenationalcampaign.org/sextech/PDF/SexTech_Summary.pdf

Tolma, E., Vesely, S., Oman, R., Aspy, C., & Rodine, S. (2006). Sexuality education beliefs among sexually experienced youth: Differences by gender and birth control use. *American Journal of Sexuality Education 1*(3), 3-23.

Tolman, D. L. (1991). Adolescent girls, women and sexuality: Discerning dilemmas of desire. In C. Gilligan, A. G. Rogers & D. L. Tolman (Eds.), *Women, Girls and Psychotherapy: Reframing Resistance* (pp. 55-69). New York: Harrington Park Press.

Tolman, D. L. (2002). *Dilemmas of desire: Teenage girls talk about sexuality*. Cambridge: Harvard University Press.

Tone, A. (2002). *Devices and Desires: A History of Contraceptives in America*. New York: Macmillian.

Turner, K. L., & Brown, C. S. (2007). The centrality of gender and ethnic identities across individuals and contexts. *Social Development, 16*(4), 700-719.

Udel, L., J. (2001). Revision and resistance: The politics of native women's motherwork. *Frontiers, 22*(2), 43-62.

United States Census Bureau. (2007). Income, poverty, and health insurance coverage in the United States: 2006. Retrieved August 19, 2008, from http://www.census.gov/prod/2007pubs/p60-233.pdf

United States Department of Health and Human Services. (2000). FDA approves Miferpristone for the termination of early pregnancy. *HHS News.* Retrieved July 30, 2008, from http://www.fda.gov/bbs/topics/news/NEW00737.html

Villarruel, A. M., Jemmott, J. B., III, & Jemmott, L. S. (2006). A randomized controlled trial testing an HIV prevention intervention for Latino youth. *Archives of Pediatrics & Adolescent Medicine, 160*(8), 772-777.

Walpole, M. (2008). Emerging from the pipeline: African American students, socioeconomic status, and college experiences and outcomes. *Research in Higher Education, 49*(3), 237-255.

Waxman, H. R. (2008). Abstinence-only education. *Committee on Oversight and Government Reform.* Retrieved July 8, 2008, from http://oversight.house.gov/investigations.asp?id=130

World Health Organization. (2004). The WHO Cross-National Study of Health Behavior in school-aged children from 35 countries: Findings from 2001-2002. *Journal of School Health, 74*(6), 204-206.

Wyche, K. F. (1993). Psychology and African-American women: Findings from applied research. *Applied & Preventive Psychology, 2*(3), 115-121.

Xu, X., Vahratian, A., Patel, D. A., McRee, A.-L., & Ransom, S. B. (2007). Emergency contraception provision: A survey of Michigan physicians from five medical specialties. *Journal of Women's Health, 16*(4), 489-498.

Younkin, E. Q. (1998). *Women's health: A primary care clinical guide* (2nd ed.). Stanford: Appleton and Lange.

Zurbriggen, E. L., Collins, R. L., Lamb, S., Robers, T.-A., Tolman, D. L., Ward, L. M., et al. (2007). Report of APA Task Force on the sexualization of girls. *Women's Program Office.* Retrieved August 29, 2008, from www.apa.org/pi/wpo/sexualization.html

APPENDIX A – IRB Consent Form

# INFORMED CONSENT
# TO PARTICIPATE IN A RESEARCH STUDY

**PROJECT TITLE:** **Exploration of Romantic Relationships in Young Women**

**PRINCIPAL INVESTIGATOR:** **Deborah Wisnieski**

**CONTACT INFORMATION:** Deborah Wisnieski by phone at (405) 271-1491 ext 49153, by e-mail (deborah-wisnieski@ouhsc.edu).

You are being asked to volunteer for a research study. This study is being conducted at a mutually agreeable private area. You were selected as a possible participant because you are a woman between the ages of 18 and 99. You have self identified as participant either from reading the flyer in the clinic or referral from a friend. Please read this form and ask any questions that you may have before agreeing to take part in this study.

The sponsor of the study is: Betty J. Harris, Ph.D.

**Purpose of the Research Study**

The purpose of this study is: to interview young women about their experiences, both positive and negative, that helped them make decisions about engaging in romantic relationships. This information will be used to help inform educators and health care providers about how to best assist young women who are making the journey through this developmental stage.

**Procedures**

If you agree to be in this study, you will be asked to do the following things: Talk about your romantic relationships in a private interview for approximately 45 minutes. The following questions will be explored.

1. Will you help me construct a diagram of your family that includes age, gender and relationships?
2. How would you describe your performance in school?
3. Did you participate in extracurricular activities?
4. Can you tell me how old you were when you started thinking about romantic relationships?
5. Did you have a group that you identified with?
6. What sorts of activities were you and your friends participating in at that time?
7. Did you discuss your romantic relationships with the following:
    a. Peers
    b. Siblings
    c. Parents
    d. Teachers
    e. Other adult friends
    f. What was the result of the discussion?
7. Where did you learn about reproduction and constructing meaning about romantic relationships?
8. Were there any adults that you were close to?
9. If you had a little sister, what would you want to tell her about relationships?

10. If you have any friends that you think would be willing to participate in this study would you give them my number and ask them to call me?
11. Are you willing to be contacted for a follow-up phone call or interview for clarification or confirmation of information?

**Risks and Benefits of Being in the Study**

1) The study has the following risks: The risks are minimal. There is a risk of embarrassment surrounding the discussion of sensitive topics of romantic relationships. However, you may discontinue the interview at any time and withdraw you participation. The information will be confidential and no identifying information will be used..

2) The benefits to participation are: 1) a better understanding of romantic relationships, 2) a sense of pride in the potential benefit in helping younger women, and 3) a sense of empowerment in future relationships.

**Compensation**

You will be given a $20 gift certificate to compensate for your time and participation in this study.

**Voluntary Nature of the Study**

Participation in this study is voluntary. Your decision whether or not to participate will not result in penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free to not answer any question or withdraw at any time.

**Confidentiality**

The records of this study will be kept private. In published reports, there will be no information included that will make it possible to identify the research participant. Tape recorded interviews will be transcribed to word processing files using numbers instead of names. There will be no identifying information in the notes. The data files will be kept in a locked file cabinet. Following the data analysis, the tapes and transcripts will be destroyed.

**Audio Recording of Study Activities**

To assist with accurate recording of participant responses, interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options.

I consent to audio recording. _____ Yes _____No.

**Contacts and Questions:**

The researcher(s) conducting this study can be contacted: Deborah Wisnieski by phone at (405) 271-1491 ext 49153, by e-mail (deborah-wisnieski@ouhsc.edu), or Betty J. Harris, by phone at (405) 325-3481, by e-mail (bharris@ou.edu), or by contacting the University of Oklahoma Department of Anthropology, 455 West Lindsey, Dale Hall Tower 521, Norman, OK, 73019.
You are encouraged to contact the researcher(s) if you have any questions.

If you have any questions about your rights as a research participant, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405.325.8110 or irb@ou.edu.

***You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.***

**STATEMENT OF CONSENT**

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

| | |
|---|---|
| Signature | Date |

# Participant Questionnaire

1. Will you help me construct a diagram of your family that includes age, gender and relationships?
2. How would you describe your performance in school?
3. Did you participate in extracurricular activities?
4. Can you tell me how old you were when you started thinking about romantic relationships?
5. Did you have a group that you identified with?
6. What sorts of activities were you and your friends participating in at that time?
7. Did you discuss your romantic relationships with the following:
    - Peers
    - Siblings
    - Parents
    - Teachers
    - Other adult friends
    - What was the result of the discussion?
8. Where did you learn about reproduction and constructing meaning about romantic relationships?
9. Were there any adults that you were close to?
10. If you had a little sister, what would you want to tell her about relationships?
11. If you have any friends that you think would be willing to participate in this study would you give them my number and ask them to call me?
12. Are you willing to be contacted for a follow-up phone call or interview for clarification or confirmation of information?

APPENDIX C – Participants Referenced in Paper

**African-Americans**
Bee  25-year-old
Brenda 27-year old
Briana 21-year-old
Bernie 26-year-old
Betty 21-year-old
Belinda 22-year-old

**Latina**
Laura 29-year-old
Lavone 22-year-old
Letty, a 29-year-old
Linda 22-year-old
Loretta 24-year-old

**American Indian**
Ally 22- year-old
Aryan 24-year-old
Anita 24-year-old
Arlene 23-year-old
Anna 24-year-old

**Euro-American**
Camile 20-year-old
Cassie 19-year-old
Catrina 21-year-old
Chris 21-year-old
Colleen 26-year-old
Connie 28-year-old
Karney 22-year-old
Karen 25-year-old
Kitty 20-year-old